STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155472	B. WING		05/16/2014
	PROVIDER OR SUPPLIEF	2	9875 C	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR IAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000000	State Licensure : included a State survey. Survey dates: M 16, 2014 Facility number: Provider number AIM number: N Survey Team:	r: 155472 N/A .NTeam Coordinator er, R.N. N. R.N. :	F000000	This plan of correction constitute written compliance for the deficiencies cited. However, submission of this plan of correction is not an admittance that a deficiency exists or that one was cited correctly. This pof correction is submitted to make the requirements established in the state and federal law.	elan eet

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155472	B. WING		05/16/2014
	ROVIDER OR SUPPLIER		9875 0	ADDRESS, CITY, STATE, ZIP CODE CHERRYLEAF DR NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000242	cited in accordan	es reflect State findings ace with 410 IAC 16.2. was completed by N on May 22, 2014.			
SS=D	SELF-DETERMIN MAKE CHOICES The resident has to activities, schedule consistent with his assessments, and with members of the and outside the far about aspects of his that are significant. Based on interviet the facility failed method of bathing who refused show bathing. (Resident #15's resident #15's resi	es, and health care or her interests, plans of care; interact ne community both inside cility; and make choices is or her life in the facility to the resident. ew and record review, I to offer an alternative ag for 1 of 1 residents wers as a method of ent #15) : ecord was reviewed on A.M. Diagnoses re not limited to, ia, depression, and	F000242	1.Resident #15 was admitted the rehab unit in the Health Center on 4/8/14. As confirmed by the state surveyors, staff do interview the resident in regard to bathing choices on 4/24/14 at that time resident had indicated the would like to take showers Resident #15 was switched from assistance with showers to assistance with bed baths on 5/16/14 and was recently discharged to home with his won 5/24/14 after completing his rehab stay. 2. There were no other residents affected. 3. In an effort to ensure ongo compliance, residents are interviewed about bathing preferences and those preferences are reflected in the residents' plan of care. CNA's	od did ds and ated

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155472	B. WIN			05/16/2014	
NAME OF P	ROVIDER OR SUPPLIER	3	-		ADDRESS, CITY, STATE, ZIP CODE		
					HERRYLEAF DR		
HOOSIEI	R VILLAGE			INDIAN.	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	responsible for filling out a	DATE	
		ntal Status]: Score: 9/15			bathing/shower sheet each tim	ne	
		airedDelirium and			they assist a resident with a		
		king: Assessment: Res			shower or bath. The		
	_	indicators of delirium or			bathing/shower sheet has bee		
	_	ing this assessment			updated to include alternatives offered as well as any behavio		
	_	Status Change: No.			exhibited during bathing (see		
	_	t: WNL [Within Normal			attachment #A). A nurse will		
	_	Evaluation:Euthymic			weekly review bathing sheets	to	
	[even mood], Ca				ensure that staff are following residents plan of care for bath	ina	
	_	ssion Scale: Type of			preference.	9	
		Q-9. Date Given: 5/5/14.			4.As a means of quality		
	· · · · · · · · · · · · · · · · · · ·	indicates minimal			assurance, the bathing/showe		
	*	rityPsychosis and			sheet audits will be reviewed we the Quality Assurance	vitri	
	Behavior Sympt				committee, quarterly, to ensure	e	
		s has not had any			that residents' bathing		
		chosis or behavior			preferences are being address	sed.	
		ssessment period.					
		or Symptoms directed					
		None. Verbal Behavior					
	-	ted towards others:					
		havior Symptoms Not					
	Directed Toward						
	Rejection of Car	e: None"					
	A 1 constant	1 113 4 (21) 2 (2) 11					
		ed "My Choices for Care"					
		rovided by the Director					
	_	/16/14, indicated the					
		for bathing was a					
		time of day he preferred					
	to bathe/shower	was Morning.					
	A document title	ed "Medicare CNA					
		ted 5/15/14, used to					
	_	re of the resident to the					
	communicate ca.	ic of the resident to the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472		LDING	NSTRUCTION 00	(X3) DATE COMPL 05/16 /	ETED
	PROVIDER OR SUPPLIER		<u>, </u>	9875 CH	DDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	•	the resident required one assist with ADL's illy Living).					
	Assessment" doo indicated in the shower in the A. indicated, the result and combative de CNA indicated, "wrong" with his he continued to swas completed. documentation of shower was stop started yelling an of bathing was of bathing	d "Daily skilled Nursing cument dated 4/28/14, "Comment" section that resident had received a M., and the CNA sident was yelling out uring the shower. The there was nothing m, he just yelled out and yell out until the shower The note had no ound to indicate the ped when the resident and an alternative means ffered to the resident. d "Daily Skilled Nursing ed 5/9/14 at 7:55 A.M., "Comment" section that refused his shower on "multiple attempts". The when the resident was did not want to take a ndicated, "Because I After the staff explained at he could go one time a king a shower and wanted to "stink" the d, "To keep everyone					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or conditions	155472		LDING		05/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	!			HERRYLEAF DR		
HOOSIEI	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A document title	ed "Nursing Assistant					
	Skin Observation	_					
		ated 5/9/14, indicated the					
		ed to take a shower three					
		used to take the shower.					
	A document title	ed "Daily Skilled Nursing					
	Assessment" dat	ed 5/13/14, indicated in					
	the "Comment"	section at 12:10 P.M., the					
	resident was con	nbative, attempted to hit					
	the nursing staff	and attempted to stand					
	up off the showe	er chair and "almost fell					
	to the floor." Th	ne resident yelled at the					
	•	water off him because it					
		note indicated, the shower					
		o the touch at the time of					
		note had not indicated					
		was stopped when the					
		t the staff to keep the					
		d became combative or					
	that another forn						
	attempted. The n						
	"Behavioral Ref						
	completed and se	ent to Social Services.					
	A document title	ed "Nursing Assistant					
	Skin Observation	_					
		ated 5/13/14, indicated					
		combative and calling					
		nower and he refused the					
	shower.						
	A document title	ed "Behavior Health					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE (COMPL	
ANDILAN	OF CORRECTION	155472	A. BUI	LDING	00	05/16/	
		155472	B. WIN			03/10/	2014
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HOOSIE	R VILLAGE				HERRYLEAF DR APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		5/13/14, indicated					
	"Describe the be	havior or action:					
	attempting to hit	staff, hitting staff.					
	yelling, cussing	at staff. Location, Date					
	and Time: 5/13/1	14. Duration (5 min, 30					
	min, 3 hours): 2	0-30 minutes, Intentional					
	and Defensive V	What occurred prior:					
	attempting to do	care, shower, and					
	accucheck. Envi	ironmental triggers:					
	shower [water w	as to hot], CNA made					
	sure water was c	ool to touch, still c/o					
	[complains] bein	g to hot. Temperature of					
	room: warmW	as resident trying to					
	communicate so	mething: that he didn't					
	want a shower T	old staff on 5/9/14 when					
	he refused show	er he wanted to stink"					
	During an interv	iew on 5/15/14 at 10:00					
	A.M., the resider	nt indicated, he did not					
	like to take show	vers and he would prefer					
	to take a bed bat	h. He indicated he did					
	not like to take a	shower because it was					
	to cold. He indi	cated he did tell the staff					
	that he did not w	ant to take his showers					
	when they took l	nim into the shower					
	room.						
	During an interv	iew on 5/15/14 at 11:51					
	_	indicated, the resident					
	· ·	ted refusing his showers					
		used his showers for her,					
		up. She indicated the					
		refused a sponge bath.					
		e had attempted to give					
		accempted to 8110					

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	OF CORRECTION OF CORRECTION 155472	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/16/2014
	PROVIDER OR SUPPLIER R VILLAGE	9875 CI	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	him a shower today and he refused times three when she took him into the shower room and attempted to get him to allow her to shower him. She notified her charge nurse. She indicated she had already given him a sponge bath when she got him up this A.M. She indicated she had not been told she was not to give this resident a shower because he had been refusing them. She did not know the resident was combative and "almost fell out of the shower chair" when staff members attempted to shower him on 5/13/14. During an interview on 5/15/14 at 4:40 P.M., the Administrator and DoN indicated if a resident became combative, started to yell or refused a shower after it was started the staff were to stop the shower and attempt an alternative way to bathe the resident. The DoN indicated the CNA's have been inserviced on bathing residents and they were shown the video "Bathing without a Battle" as an instruction tool for bathing residents without the resident being combative. During an interview on 5/16/14 at 10:10 A.M., LPN #2 indicated on 5/13/14, when the CNA attempted to give the resident his shower, he refused due to the water being "hot" and she attempted to adjust the water. When the CNA could			

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	of Correction identification number: 155472	A. BUILDING B. WING	00	COMPLETED 05/16/2014
	PROVIDER OR SUPPLIER R VILLAGE	STREET A 9875 CI	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	not get the water adjusted, then she placed the resident in his wheelchair and brought him out of the shower. He continued to be agitated for the duration of 20-30 minutes following the shower attempt and he did not allow LPN #2 to attempt his accucheck until later. LPN #2 indicated, the facility did not have a tub bath to offer as an alternative approach to the shower for this resident. She indicated as far as she knew the staff had not tried any other alternative means to offer to routinely bathe this resident. She indicated if the resident was offered an alternative means of bathing there should have been documentation in the nurses notes and the alternative bathing method would have been documented on the "CNA Assignment Sheet." 3.1-3(u)(3)			

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	COMPLETED
		155472	B. WING		05/16/2014
	PROVIDER OR SUPPLIER		9875 C	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR JAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
F000279 SS=D	PLANS A facility must use assessment to det the resident's common The facility must do care plan for each measurable object meet a resident's imental and psycholidentified in the common The care plan must that are to be furnithe resident's high mental, and psycholidentified under \$44 that would otherwis \$483.25 but are not resident's exercise including the right \$483.10(b)(4). Based on interviet the facility failed comprehensive Care, refusing she	the results of the velop, review and revise prehensive plan of care. evelop a comprehensive resident that includes tives and timetables to medical, nursing, and osocial needs that are imprehensive assessment. St describe the services ished to attain or maintain est practicable physical, iosocial well-being as 83.25; and any services se be required under of provided due to the er of rights under §483.10, to refuse treatment under ew and record review,	F000279	The facility acknowledges the F242 and F279 are in regard the same resident and same issue. 1. Changes were made to Resident #15 plan of care or	ds to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		COMPLETED
		155472	A. BUILDING B. WING		05/16/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		CHERRYLEAF DR	
HOOSIE	R VILLAGE			NAPOLIS, IN 46268	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		BATE
	Plans. (Resident	t #15)		5/16/14 to reflect resisting car	•
				and refusing showers during t survey process, therefore hav	
	Findings include:			already been addressed.	
				2.There were no other resid	ents
	Resident #15's r	ecord was reviewed on		affected.	
	5/15/14 at 7:12	A.M. Diagnoses		3.In an effort to ensure ongo	
		ere not limited to,		compliance, any resident with evidence of resistance to care	
		tia, diabetes mellitus, and		have it addressed in that	, will
	depression.	,		individuals care plan. CNA's a	ıre
				responsible for filling out a	
	A document title	ed "Daily skilled Nursing		bathing/shower sheet each tir	ne
	A document titled "Daily skilled Nursing Assessment" dated 4/28/14, indicated in			they assist a resident with a	
				shower or bath. The bathing/shower sheets have to	100n
		section at 4:30 P.M., the		updated to include alternative	• • • • • • • • • • • • • • • • • • •
		eived a shower in the		offered as well as any behavior	• • • • • • • • • • • • • • • • • • •
	· ·	NA indicated the resident		exhibited during bathing. The	
		and combative during the		MDS/Care Plan RN will audit	
		NA indicated there was		nurses' notes of residents in t	
	1	with him, he just yelled		Medicare unit weekly to ensure that their plan of care is reflect	
	out and he conti	nued to yell out until the		of any resistance of care and	• • • • • • • • • • • • • • • • • • •
	shower was con	npleted.		interventions are put in place.	
				4. As a means of quality	
	A document title	ed "Daily Skilled Nursing		assurance, results of the wee	kly
	Assessment" da	ted 5/9/14 at 7:55 A.M.,		audits of nurses notes will be reviewed with the Quality	
	indicated in the	"Comment" section that		Assurance Committee, quarte	rlv.
	the resident had	refused his shower on		quarte	, l
	this A.M. after '	'multiple attempts". The			
		when the resident was			
		did not want to take a			
		indicated, "Because I			
		After the staff explained			
		nat he could go one time a			
		king a shower and			
		•			
		wanted to "stink" the			
	resident indicate	ed, "To keep everyone			

	OF CORRECTION IDENTIFICATION NUMBER: 155472	A. BUILDING B. WING	00	COMPLETED 05/16/2014
	PROVIDER OR SUPPLIER R VILLAGE	9875 CHER	RESS, CITY, STATE, ZIP CODE RRYLEAF DR OLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
	away." He refused to allow the staff to shave his mustache.			
	A document titled "Daily Skilled Nursing Assessment" dated 5/13/14, indicated in the "Comment" section at 12:10 P.M., the resident became combative, attempted to hit staff and attempted to stand up off the shower chair and "almost fell to the floor." The resident yelled at the staff to keep the water off him because it was "hot." The note indicated a "Behavior Referral Form" was completed for Social Services. A document titled "Nursing Assistant Skin Observation Report With Shower/Bath" dated 5/13/14, indicated the resident was combative and calling out during the shower and he refused the shower. A document titled "Behavior Health Referral" dated 5/13/14 indicated "Describe the behavior or action: attempting to hit staff, hitting staff. yelling, cussing at staff. Location, Date and Time: 5/13/14. Duration (5 min, 30 min, 3 hours): 20-30 minutes, Intentional and Defensive What occurred prior: attempting to do care, shower, and accucheck. Environmental triggers: shower [water was to hot], CNA made sure water was cool to touch, still c/o			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE COMPL		
111,12 12,111,	or condition	155472		LDING		05/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SECULD TO THE A DEFICIENCY)		TE	COMPLETION
TAG		leing to hot. Temperature		TAG	DLI ICENCI)		DATE
		.Was resident trying to					
		mething: that he didn't					
	want a shower Told staff on 5/9/14 when						
		er he wanted to stink"					
	During the clinic	cal record review there					
	were no Care Pla	ans for resisting care,					
	_	s or accucheks found					
	documented.						
	D : : .	. 7/17/14 + 10 10					
	1	riew on 5/16/14 at 10:10					
	•	ndicated on 5/13/14, attempted to give the					
		wer, he refused due to the					
		and she attempted to					
		When the CNA could					
	_	adjusted, then she					
		ent in his wheelchair and					
	_	of the shower. He					
	continued to be	agitated for the duration					
	of 20-30 minutes	s following the shower					
	_	lid not allow LPN #2 to					
	attempt his accu	check until later.					
	During an inter-	riew on 5/16/14 at 3:13					
		Manager indicated the					
		fusing showers and					
	_	Plans were not initiated					
		nimum Data Set)					
		il 5/16/14, after the issue					
		ving Care Plans for these					
	concerns were b	_					
	Administrator an	nd DoN's attention on					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155472	A. BUILDING	00	05/16/2014
		133472	B. WING		03/10/2014
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 75 CHERRYLEAF DR	
HOOSIEI	R VILLAGE			DIANAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	CROSS-REFERENCED TO THE APPROP	BE COMPLETION
	5/15/14 at 4:40 F 3.1-35(a) 3.1-35(b)(2)	P.M.			
F000282 SS=D	CARE PLAN The services provifacility must be propersons in accordance written plan of care. Based on observer record review, the Plan of Care intellimplemented, relateratment to heal 11 residents review (Resident #9) Findings follow: On 5/12/14 at 2:	ance with each resident's e. ation, interview and he facility failed to ensure herventions were ated to repositioning as a hard pressure ulcer; for 1 of hewed for Care Plans.	F000282	1.All CNAs go through sk training upon hire and an ain a CNA workshop where sincluding repositioning and following assignment sheet plans are addressed. The Caring for Resident #9 on 5 was immediately re-in-servi on following residents' plan care and repositioning. 2.There were no other resaffected. 3.In an effort to ensure or compliance, a mandatory a	nnually skills s/care CNA /15/14 iced of sidents

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155472	B. WIN			05/16/2014	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			HERRYLEAF DR		
HOOSIE	R VILLAGE				APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDER'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with her eyes closed.				health center nursing staff		
	-				in-service with signature requi	red	
	In an interview on 5/13/14 at 10:00 A.M.,				will be conducted 6/3/14 and		
		d the resident had a Stage			6/10/14 to review following residents plan of care, including		
		on her left buttock,			repositioning of dependent	ig	
	_				residents.		
	winen was acqui	ired in the facility.			4.As a means of quality		
	0 5/10/14 / 0	00 A M (1			assurance, nurses will perform		
		00 A.M., the resident			weekly audits to ensure reside	nts	
		in her wheelchair in the			plan of care for offloading and repositioning is being followed		
	, ,	room. The resident			Results of the audits will be		
	•	ner wheelchair until after			shared with the Quality		
	the lunch meal.	At 1:40 P.M., the			Assurance Committee quarter	ly.	
	resident was trar	nsferred into bed from the					
	wheelchair with	a Hoyer (mechanical)					
	lift. During an i	nterview at 1:40 P.M., a					
	family member i	indicated the resident					
	becomes very tir	red when up all morning.					
	<u>-</u>	e resident seemed very					
		nd figured the resident					
	had been up a lo	•					
	naa ocen ap a ro	ng time.					
	On 5/13/14 at 3.	15 P.M., the resident was					
		15 1 .w., the resident was 1 bed, laying on her back.					
	There was a spec	•					
	_	nattress overlay on the					
	bed.						
	0 5/11/11	200 4 3 6 11					
		0:20 A.M., the resident					
		oom. A 3 to 4-inch foam					
	- 1	attress overlay, for					
		vas observed on top of					
	the mattress. Th	ne resident was located in					
	the therapy depa	rtment, and was					
	observed to be to	ransferred by one					

X5)
LETION ATE

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	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/16/2014
	PROVIDER OR SUPPLIER R VILLAGE	9875 CI	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	In:45 A.M. The COTA was observed kneeling by the recliner, and talking with the resident. At 12:30 P.M., the resident's lunch tray was delivered. The resident remained in the recliner chair. The gel seat pad was observed to be in the wheelchair. CNA #3 indicated she would lay the resident down after lunch, probably in about an hour. No nursing staff were observed to go into the resident's room between 10:30 A.M. and 12:30 P.M. On 5/15/14 at 1:30 P.M., the resident was observed to be in her bed. CNA #5 and CNA #4 indicated they had just transferred the resident into bed using the mechanical lift. After rolling the resident to her left side, CNA #5 used a disposable wipe to clean the resident's rectal and buttock area. The adult brief that had been on was wet with urine, and both buttock areas were reddened with white "wrinkle" marks. There was a small (pencil point) round open area on the lower right buttock. There was a white colored, irregular-edged area at the coccyx that appeared to be scar tissue. No open area was observed on the left buttock. After cleaning the resident's bottom and applying a clean brief, the CNAs positioned the resident on her back.			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	TE SURVEY MPLETED 16/2014
	PROVIDER OR SUPPLIER		9875 CI	ADDRESS, CITY, STATE, ZIP CO HERRYLEAF DR APOLIS, IN 46268	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOPE)	ERENCED TO THE APPROPRIATE	
	5/15/14 at 10:40 included, but we history of a left I reduction/internal history of weight seizures, congest urinary tract infel hypoxia, and history vascular accident expressive aphase. The May, 2014 If (recapitulation) for orders, with date 4/9/14Anti-prelas pressure relief 4/9/14Foam ov 4/19/14Keep of until open area history of the continuous mobility;" and "for the continuous of the continuous	Physician Order recap form included current e ordered, as: ssure wheelchair cushion f. verlay as pressure relief. ff of back when in bed				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE Co	00	COMF	E SURVEY PLETED 6/2014
	PROVIDER OR SUPPLIER		9875 C	ADDRESS, CITY, STATE, ZIP (CHERRYLEAF DR NAPOLIS, IN 46268	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	between 7-8:30 A	indicated "Get up A.M.; bed right after it; Reposition every 2				
	P.M., the Admin Nurses were give provide any info	ence on 5/15/14 at 4:30 istrator and Director of en the opportunity to rmation/documentation cloading/repositioning of				
	dated 5/15/14 (n indicated the dod was the response the Physical The and Certified Oc	rovided a typed note, to time listed). She cumentation on the note tes from interviews with the rapist Assistant (PTA) cupational Therapy				
	#7], with HTS [t company], he en name] room betw She was up in he assess her," and with HTS, stated [resident's name] Resident still in repositioned resident/footrests so	ted "Per therapist [PTA he contracted therapy tered [the resident's ween 11:30 am-12 noon. er chair. He went in to "Therapist [COTA #8), I she went in to I room after [PTA #7]. her chair. [COTA #8] dent to include her as to facilitate a more ition for the resident."				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155472 A. BUILDING B. WING			COMPLETED 05/16/2014		
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	COTA #8 indicate were elevated on when she went in lowered the foot place an over-bed resident. She included the resident she did not at the resident's bod. In an interview of PTA #7 indicated room for 15 minutes and the resident was very any care. He indicated the resident was very any care.	n 5/16/14 at 3:00 P.M., If he was in the resident's ates. He indicated the vired and resistant to dicated he gently moved not rest, but did not				
F000314 SS=D	PRESSURE SORI Based on the com a resident, the faci resident who enter pressure sores do sores unless the ir condition demonst unavoidable; and a sores receives ned services to promot	prehensive assessment of lity must ensure that a is the facility without es not develop pressure idividual's clinical rates that they were a resident having pressure dessary treatment and				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURV	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETEI	
		155472	B. WIN	IG		05/16/201	4
	PROVIDER OR SUPPLIEF		•	9875 C	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAU	developing. Based on observed record review, the service of the se	ation, interview and ne facility failed to ensure had pressure ulcers, was cloaded from her bottom in the healing of Stage 2 for 1 of 2 residents ssure ulcers. (Resident	F00	00314	The facility acknowledges F28 and F314 are in regards to the same resident and same issue 1.All CNA's go through a ski training initially upon hire and annual CNA workshop where skills including repositioning a following residents plan of car are addressed. The CNA carir for resident #9 on 5/15/14 was immediately re-in-serviced on following residents' plan of car and repositioning. 2. There were no other resid affected 3. In an effort to ensure ongo compliance, A mandatory nurs in-service with signature requi will be conducted on 6/3/14 at 6/10/14 to review following a residents plan of care. 4. As a means of quality assurance, spot check audits ensure residents plan of care offloading and repositioning where performed by nurses. Rest of the audits will be shared with the Quality Assurance committing quarterly.	e e e e e e e e e e e e e e e e e e e	5/13/2014

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472		LDING	NSTRUCTION 00	(X3) DATE COMPL 05/16	ETED
	PROVIDER OR SUPPLIER		<u> </u>	9875 CH	DDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	: IATE	(X5) COMPLETION DATE
	observed to be in There was a spec pressure-relief m bed. On 5/14/14 at 10 was out of her ro "waffle" type ma pressure relief, we the mattress. The the therapy depart observed to be to Physical Therapy gait belt, from we chair. The reside some weight, an pivot with maximal therapist. There covered gel press wheelchair. On 5/14/14 at 11 was observed sit the lounge area as Station. She was around.	15 P.M., the resident was a bed, laying on her back. Ealty foam nattress overlay on the extremely some at the som. A 3 to 4-inch foam attress overlay, for was observed on top of the resident was located in a rement, and was cansferred by one by staff member, using the elchair to regular the some and was able to bear down able to perform a mum assistance from the was a leather/vinyl sure-relief cushion in the extremely sure-relief cushion in the some and looking the perform the necross from the Nurse's some and looking the performance of the same and looking the performance of the same and looking the performance of the same and looking the performance of the performance					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 05/16/	ETED
	PROVIDER OR SUPPLIEF			STREET A	DDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	since before lune	d been with the resident ch, about 11:30 A.M., had been up in her then.					
	was made from P.M. At 10:30 A observed sitting room, with back angle. Her legs rest. The gel cus wheelchair. At Occupational The entered the room 11:45 A.M. The kneeling by the resident remaine The gel seat pad the wheelchair. would lay the reprobably in about staff were observed to be in CNA #4 indicate transferred the remechanical lift.	11:30 A.M., a Certified herapy Assistant (COTA) in, and remained until a COTA was observed recliner, and talking with 12:30 P.M., the tray was delivered. The red in the recliner chair. was observed to be in CNA #3 indicated she sident down after lunch, at an hour. No nursing wed to go into the retween 10:30 A.M. and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	COMPL		
ANDILAN	OF CORRECTION	155472		LDING	00	05/16/	
		155472	B. WIN			03/10/	2014
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HOOSIE	R VILLAGE				HERRYLEAF DR APOLIS, IN 46268		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ndone the adult brief.					
	_	resident to her left side,					
		sposable wipes to clean					
		tal and buttock area.					
		hat had been on was wet					
	•	ooth buttock areas were					
		hite "wrinkle" marks.					
		ll (pencil point) round					
	-	lower right buttock.					
	There was a whi	,					
		area at the coccyx that					
	* *	car tissue. No open area					
		the left buttock. After					
	_	dent's bottom and					
	applying a clean						
	positioned the re	sident on her back.					
		ord was reviewed on					
		A.M. Diagnoses					
	•	re not limited to, recent					
		nip fracture with open					
		al fixation, chronic pain,					
	, ,	t loss, vascular dementia,					
	, ,	tive heart failure, chronic					
	-	ection, constipation,					
	7 .	tory of a cerebral					
		t (CVA/stroke) with					
	expressive aphas	514.					
	An acute care ho	spital "Admission					
	History and Phys	sical" report, dated					
		the resident was					
	"awake, alert, do						
		priented to person, place					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	TE SURVEY MPLETED 16/2014
	PROVIDER OR SUPPLIER		9875 CI	ADDRESS, CITY, STATE, ZIP CO HERRYLEAF DR APOLIS, IN 46268	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	previous stroke She is essentially	cant dementia as well as with expressive aphasia. y confided to a does not ambulate."				
		ted 4/9/14, indicated ncision left hip, bruise				
	assessments, dat indicated the res	ressure ulcer risk ed 4/9/14 and 5/6/14, ident had scores of "14" score of 12 or less I RISK").				
	(recapitulation) orders, with date 4/9/14WBAT (LLE (left lower 4/9/14Anti-pre	(weight bear as tolerated) extremity) ssure wheelchair cushion				
	4/9/14Moisturd peri-anal area ev needed).	f. verlay as pressure relief. e barrier cream to very shift and PRN (as				
	open area right uand PRN until he	upper buttock every shift ealed. ff of back when in bed				
	Other MD order	s included, but were not				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155472	B. WIN			05/16/	2014
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	KOVIDER OR SUPPLIER			9875 CI	HERRYLEAF DR		
HOOSIEI	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	limited to, the fo	•					
	5/9/14Disconti						
	_	right buttockopen area					
	healed.						
	A Dlancistan						
		gress note, dated 5/5/14,					
	,	patient) has a Stage III					
	1 ^	her left buttock per					
		risk for skin breakdown					
		ty, incontinence, and					
		ry abilities. She is					
	1	ressure relief pad in her					
		nair and is put in bed after					
	meals. Staff has	been applying					
	Calmoseptine to	the area. Skinleft					
	buttock, small st	age ll pressure ulcer					
	approx. 0.25 by	0.25 by 0.25 cm. Nurse					
	reports it looks r	nuch better than it did					
	last week, not as	deep"					
	I	ed Nursing Assessment"					
	notes indicated t	•					
	4/19/14, at 2:35	P.M"CNA reported to					
	this nurse earlier	resident has open area					
	to right buttock.	Noted Stage 2					
	crescent-shaped	open area to right upper					
	buttock"						
	4/20/14Left hip	p (surgical incision) and					
	right upper butto	ock.					
	5/7/14right and	l left buttocks.					
		ock and right buttock.					
		en area on left buttock					
	done as ordered.						
		ock. Treatment to open					
	Sisin Ton out	on. Heatinest to open					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155472	B. WIN			05/16/2014	
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
HOOSIE	R VILLAGE				HERRYLEAF DR APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X:	•
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLE DAT	
IAG	left buttock done	·		TAG	,	DAI	L
		ttock. Open area to left					
	buttock slowly h	•					
		ttock. Treatment of open					
		done as ordered. Wound					
		pink granular tissue					
	present.	F - 0-1111111111111111111111111111111111					
	1						
	In an interview of	on 5/16/14 at 3:30 P.M.,					
	LPN #5 indicate	ed the resident has had					
	open areas on bo	oth her right and left					
	buttock areas.	· ·					
	The "Wound As	sessment Form" reports					
	indicated the fol	lowing:					
	4/19/14Right u	ipper buttock, Stage 2,					
	shearing, 1.7 by	0.7 by 0.1 cm					
	(centimeter)						
		ipper buttock, Stage 2,					
	1.5 by 1.0 by 0.1						
		ittock, pressure. Right					
	buttock wound h	•					
		tock, Stage 2, pressure;					
	0.3 by 0.2 by 0.2						
		tock, Stage 2, pressure;					
		2 cm. No change in					
	wound this week	ζ.					
	One Care Plan e	entry addressed a problem					
		ential for skin breakdown					
	, ,	inence and decreased					
		(Not dated) Open areas to					
		ventions were listed as:					
	"Encourage to d	rink fluids daily; barrier					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155472	B. WIN	G		05/16/	2014
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		h incontinent episode;					
		ered; encourage out of					
	· ·	bs as ordered; foam					
		aced on mattress for					
		provide diet as ordered;					
		lchair for pressure relief;					
	continue on supp	plements for wound					
	healing; reposition	on side to side."					
	A "Medicare CN	JA Assignment" sheet,					
	updated 5/14/14	, indicated "Get up					
	between 7-8:30	A.M.; bed right after					
	dinner; Hoyer lit	ft; Reposition every 2					
	hours."						
	During a confere	ence on 5/15/14 at 4:30					
	P.M., the Admin	nistrator and Director of					
	Nurses were give	en the opportunity to					
		rmation/documentation					
	l	f-loading/repositioning of					
	the resident.						
	On 5/16/14 at 10):10 A.M., the					
		rovided a typed note,					
		o time listed). She					
	` `	te was the responses from					
		the Physical Therapist					
	Assistant (PTA)	3					
		nerapy Assistant (COTA)					
		h Resident #9 on					
		ted indicated "Per					
		² 7], with HTS [the					
	· ·	py company], he entered					
	the resident's na	nme] room between 11:30					

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Event ID: V13I11

Facility ID: 000548

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PRINTED: 09/16/2014 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	LDING	NSTRUCTION 00	(X3) DATE COMPL 05/16 /	ETED
	ROVIDER OR SUPPLIER		9875 CH	DDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268	-	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	He went in to ass [COTA #8), with to [resident's nar Resident still in repositioned residents so comfortable positions of the resident still in the reside	on 5/16/14 at 3:00 P.M., d he was in the resident's utes. He indicated the y tired and resistant to licated he gently moved bot rest, but did not				
F000371 SS=F	483.35(i) FOOD PROCURE STORE/PREPARI The facility must -	:, E/SERVE - SANITARY				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V13I11

Facility ID: 000548

If continuation sheet Page 28 of 69

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DI 111	DDIC	00	COMPL	ETED
		155472		LDING		05/16/2014	
			B. WIN		ADDRESS SITE STATE SID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
	2.1/11.1.05				HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	(1) Procure food f	rom sources approved or					
	considered satisfa	actory by Federal, State or					
	local authorities; a	and					
		, distribute and serve food					
	under sanitary co	nditions					
	Based on observ	ration, interview and	F00	0371	1.On 5/12/14, the "well" p		06/13/2014
	record review, th	ne facility failed to ensure			with debris & wet were remove		
	1 of 1 facility ki	tchen food storage areas,			from use and taken to the dish		
	_	and food equipment			room for cleaning and sanitizir 2.The well pan was remo		
		in a safe and sanitary			from service, therefore no	veu	
		•			residents were affected.		
		owed sanitation and food			3.In an effort to ensure		
	safety policies a	nd procedures. This			ongoing compliance, all Health	ı	
	deficiency impa	cted 11 of 11 residents			Center Dining Services		
	who received for	od from the kitchen.			Employees will be re-trained p	er	
					policy on proper cleaning,		
	Findings include				air-drying, and inverted storag		
	rmunigs meruuc				pans per policy. Staff in-servic		
					be conducted on 6/4/14, 6/11/	14,	
	On 5/12/14 at 10	0:30 A.M., the kitchen			and 6/12/14. Utility staff will		
	tour was comple	eted, with the Registered			ensure this practice is followed		
	Dietician (RD) a	and the Dining Supervisor			a consistent basis by the daily Utility Staff Checklist. Weekly		
	in attendance. T	he following was			random visual checks will be		
	observed:	8			conducted by a dietary manag	er.	
	observed.				4.As a means of quality		
	O !! 11!! 3	na and analysis of			assurance, the weekly visual		
	•	had dried debris inside on			audits done by dietary		
		e pan. Another "well"			management will be reviewed		
	pan had moistur	e on the inside walls,			with the Quality assurance		
	which dripped d	own the inside walls			committee quarterly.		
	* *	In an interview at that			1. On 5/12/14 the black spill in		
	• •	licated the pans should			the oven was cleaned. 2. The	spiii	
		r moisture in them.			in the oven was immediately cleaned, therefore there were	no	
	nave no debits o	i moisture in mem.			residents affected. 3. In an effe		
					to ensure ongoing compliance		
		baked, black residue			Dietary Health Center Product		
	inside on the bot	tom of the oven floor. In			Employees will be re-trained p		
	an interview at t	hat time, Dietary Cook			policy, on proper oven &		
		e oven was cleaned			equipment cleaning. Staff		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155472	A. BUIL B. WING			05/16/	2014
		l .	D. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			HERRYLEAF DR		
HOOSIEI	R VILLAGE				APOLIS, IN 46268		
					7.1 J. 200, 114 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	<u> </u>		DATE
		eved the weekend staff			in-service to be conducted on 6/4/14, 6/11/14, and 6/12/14.		
	were to clean it.				Random weekly visual checks	will	
					be conducted by a dietary	WIII	
	A sanitation buc	ket containing a			manager to ensure proper ove	en	
		on was observed sitting			and equipment cleaning is bei		
		table. In an interview at			done4. As a means of quality	-	
					assurance, the weekly visual		
		y Cook #15 indicated he			audits done by dietary		
		solution in the bucket at			management will be reviewed		
		I. Dietary Aide #14			with the Quality assurance		
	checked the con-	centration of the			committee quarterly. 1.The sanitation bucket w	uae	
	sanitation solution	on in the bucket, and			immediately removed and	vas	
	indicated it was	reading at 100 parts per			replaced with sanitizing solution	n	
	million (ppm) S				at 200 ppm.		
	• • •	on should be at 200 ppm.			2.The sanitation solution		
	Samanon Solution	m should be at 200 ppin.			was replaced with solution tha	t	
	F1	11 1 6:			was 200ppm, therefore no		
		ed bowls of ice cream			residents were affected.		
		n the middle shelf in one			3.In an effort to ensure		
	of three freezers	. The RD indicated the			ongoing compliance, all Health	ו	
	ice cream should	l have been covered.			Center Dining Services Employees will be re-trained p	ωr	
					policy on proper use of sanitiz		
	An ice scoon wa	s observed to be in the			solution and frequency of	9	
	_	chine. The Dining			changing sanitation solution pe	er	
		•			policy. Staff in-service to be		
	_	ated the scoop should not			conducted on 6/4/14, 6/11/14,		
	be left in the ice	inside of the ice			and 6/12/14. Health Center		
	machine.				Dining Services Employees ar	nd	
					management will ensure the		
	The floor underr	neath a food rack in the			sanitation solution is being changed per policy as evidence	had	
	dry storage room	n was observed to have a			on the daily Utility Staff Check		
		of debris. The Dining			Random weekly visual checks		
		ated staff were supposed			be conducted by a dietary		
	_	* *			manager to ensure the sanitizi	ing	
	•	op daily in dry storage			solution has been changed ou	-	
	area, but the staf	f must have missed that			and at the appropriate		
	area.				concentration.		
					4.As a means of quality		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155472	A. BUII			05/16/	2014
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The policies for	the ice machine,			assurance, the weekly visual		
		l in freezer, schedule for			audits done by dietary		
		-			management will be reviewed		
		s and the dry storage			with the Quality assurance		
	rack areas were	requested at that time.			committee quarterly.		
					D.		
	On 5/12/14 at 3:	30 P.M., the Registered			1.The eleven ice creams		
	Dietician provid				were immediately discarded.		
		which she indicated was			2.The eleven ice creams		
	all she could fine				were immediately discarded therefore there were no reside	nte	
	an she could line	u.			affected.	1113	
					3.All Health Center Dining	n	
	An undated docu	ument, titled "The Cooks			Services Employees will be	9	
	Cleaning Schedu	ıle," was typed out			re-trained on proper covering,		
	indicating which	days of the week which			labeling, and dating of product	S	
		completed. There was			per policy. Staff re-training to b		
		-			conducted on 6/4/14, 6/11/14,		
		the list regarding the			and 6/12/14. Dining Services s		
	cleaning of oven	IS.			and management will ensure t	his	
					practice is followed on a		
	An undated docu	ument, titled "The			consistent basis by the daily		
	Servers Extra Cl	eaning," indicated the			Dining Staff Checklist. Randor	n	
		was to be organized,			weekly visual checks will be	0.5	
					conducted by a dietary manag to ensure staff are coving,	еі	
	Swept and mopp	ed on Thursdays.			labeling and dating products		
					appropriately.		
	An undated doci	ament, titled "Food			4.As a means of quality		
	Handling Guidel	lines (HACCP),"			assurance, the weekly visual		
	indicated "pag	e 5 of			audits done by dietary		
		When the food is placed			management will be reviewed		
		uipment (walk-in, blast			with the Quality assurance		
					committee quarterly.		
	· · · · · ·	Loosely covered or			E		
	_	tected from overhead			1.The Manitowac ice		
	contamination	"			machines are designed with a	41	
					ledge inside the bin that holds	tne	
	An undated doci	ument, titled " EcoLab			scoop, while not allowing it to	nt .	
	Sanitizer Techni	-			touch the ice. This is consister with the department policy.	IL	
					2.There were no resident	e	
	indicated, "the	concentration of the quat			2. THELE WELL HOTESIGERIL	3	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155472	A. BUI B. WIN			05/16/	2014
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
	canitizing colution	on must be between	1		affected.		
	_				3.In an effort to ensure		
	200-400 ppm'				ongoing compliance, all Health	ı	
					Center Dining Services		
	A Policy, titled '	'Sanitation and Infection			Employees will be re-trained o	n	
	•	dling" and dated 5/95			proper storage of the ice scoo		
		late of 1/14, indicated			Staff re-training to be conducted		
					on 6/4/14, 6/11/14, and 6/12/1		
		Nutrition Services			Dining Services staff and		
		ociatesStore the scoop			management will ensure this		
	in a self-draining	g container in an area			practice is followed on a		
		contamination. The scoop			consistent basis by the daily		
	1 ^	in the ice bin"			Dining Staff Checklist. Randor	n	
	cannot be stored	in the ice oni			weekly visual checks will be		
					conducted by a dietary manag	er	
	3.1-21(i)(3)				staff are following ice scoop		
					storage policy.		
					4.As a means of quality		
					assurance, the weekly visual		
					audits done by dietary		
					management will be reviewed		
					with the Quality assurance		
					committee quarterly.		
					1.The spot of debris		
					observed on the floor underne	ath	
					the food rack in the dry storage		
					area was estimated to be		
					approximately 2" in diameter.	The	
					spot was immediately cleaned		
					and appeared to be jelly that h		
					dropped.		
					2.There were no resident	s	
					affected.		
					3.In an effort to ensure		
					ongoing compliance, All Healtl	n	
					Center Dining Services		
					Employees will be re-trained p	er	
					policy on proper daily and/or a		
					needed, sweeping and moppir	ng	
					of kitchen floors. Staff re-traini	ng	
					to be conducted on 6/4/14,		

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		IDENTIFICATION NUMBER: 155472	A. BUILDI		00	COMPL 05/16/	ETED
			B. WING	TD PPT	DDDEGG GITW GT TT CORE	33, 13,	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
HOOSIE	R VILLAGE				HERRYLEAF DR APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX `AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F000411 SS=D	483.55(a) ROUTINE/EMERO SERVICES IN SNI The facility must a routine and 24-hou A facility must provoutside resource, i §483.75(h) of this emergency dental needs of each resi Medicare resident routine and emerg must if necessary, making appointme transportation to a office; and prompt or damaged dentu Based on intervie the facility failed was assessed, and dental services w resident who had	GENCY DENTAL FS ssist residents in obtaining ar emergency dental care. Vide or obtain from an n accordance with part, routine and services to meet the dent; may charge a an additional amount for ency dental services; assist the resident in nts; and by arranging for nd from the dentist's by refer residents with lost res to a dentist. Ew and record review, to ensure dental status d assistance in obtaining tras provided, for 1 experienced tooth loss; at reviewed for dental	F0004		6/11/14, and 6/12/14. Utility sta and management will ensure the practice is followed on a consistent basis by the daily Utility Staff Checklist. Random weekly visual checks will be conducted by a dietary manager to ensure routine cleaning is being completed. 4.As a means of quality assurance, the weekly random visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. The facility is requesting a face face IDR for F411. Hoosier Village consistently complies we the regulation to assist resident in obtaining routine and 24-hou emergency dental care. As indicated by the surveyors, resident #9 was sent out for	his tility ly d e to	06/06/2014

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Event ID: V13I11

Facility ID: 000548

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T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/16/2014
PROVIDER OR SUPPLIEI	<u>.</u>	STRE 987	EET ADDRESS, CITY, STATE, ZIP CODE 5 CHERRYLEAF DR IANAPOLIS, IN 46268	
SUMMARY S (EACH DEFICIENT REGULATORY OF FINDINGS included In an interview of P.M., a family in Resident #9 had recent hip surge indicated she has appointment with member indicated aware the resided were checking of She indicated the placed on a on a she indicat	tratement of deficiencies and must be preceded by full also identifying information) e: on 5/13/2014 at 1:09 anember indicated lost 2 teeth following her and not yet made an and dentist. The family and nursing staff were and had lost teeth, and an her ability to chew. are resident was recently and mechanical soft diet. ord was reviewed on a.M. Diagnoses are not limited to, recent with open al fixation, chronic pain, at loss, vascular dementia, asophageal reflux disease, failure, chronic urinary 8-12 vitamin deficiency, definitions of CVA are accident/stroke) with		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY) dental work approximately 3 months earlier for a similar of issue. At the daughter's requishe made that appointment convenience and notified nustaff who then arranged transportation for the reside which is in accordance with regulation F 411. Resident # daughter visits her mother of daily basis and has requested be responsible for making a appointments for her mother noted by the surveyor, this will documented in the Care Pladated 2/5/13 for a problem addressed as "Dental Care" an intervention which stated "family will decide on follow-care." On 5/10/2014, Reside #9's daughter notified nursir staff that her mother's tooth missing but that she wanted wait until later to make a decide appointment. There were not indications — bleeding, grims change in appetite, etc the emergency care was needed fact, as stated by the survey nurses documentation indicated that the resident had a good ate 100% of her breakfast, a took all of her medications will difficulty. As a precaution to prevent chewing issues, the resident was placed on a	dental dest, at her dest, at her dest, at her dest to
2/28/14, indicate	ed "Had a tooth filled and othesiashe did well; no		mechanical soft diet. The nudid assess the resident's mas stated in the nurses note in verbal conversation with the surveyor on 5/15/2014. In four conversation with Resident	outh s and he illow

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155472	B. WIN			05/16/2	2014
	DOLUMBER OF START		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HERRYLEAF DR		
	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A "Care Plan Re	view" form, dated			#9's daughter on 5/19/2014, th		
	3/4/14, indicated	"Resident missing 1/2			daughter again stated, this tim		
	front tooth."				the Director of Nursing, that she did not want her mother sent t		
					the dentist at this time and tha		
	A Nurse's Notes	entry, dated 5/10/14 at			she would make the appointm		
		•			at a later time. Due to the		
	-	nted "[Family member]			resident's debility, she require	s	
		. States resident has a			general anesthesia for any de		
	_	lesident has had a good			work, including that which is		
	day today. Ate 1	00% breakfast this			routine. Since the resident has	3	
	morning. Took a	all meds [medications]			recently fractured her hip		
	with no difficulty	y Tooth with brown			requiring surgery under gener		
		oth where broken off"			anesthesia, the daughter does not want her undergoing anyth		
		our where broken orr			else at this time. Since the	iiig	
	TEI	1 (3)			discovery of the missing tooth		
		ibsequent Nurses			the resident has not displayed		
	progress notes re	lated to the broken			any adverse symptoms, i.e., fa		
	tooth.				grimaces, crying out, a change		
					eating patterns, fever, that		
	There were no So	ocial Service notes			indicate a need for emergent		
	related to the res	ident's dental status.			care. To comply with regulation		
		Suring Suring.			411, nursing staff are not requ		
	The Mer. 2014 F	Ohygigian Order recor			to make a referral to the socia services designee for emerger		
		Physician Order recap			or routine dental needs. Nursi		
		sheet, included current			staff can, and do, initiate	a	
	•	date ordered, as follows:			conversations with families an	d l	
	4/9/14Regular	diet			assist with making dental		
	4/9/14Tylenol :	325 mg. (milligrams)-			appointments if the resident or		
	-take 2 tablets O	ID (four times a day)			their representative agrees. In		
	•	1 bottle in between			this case, the daughter noticed	d	
	mealsDx. supp				the tooth missing, notified the		
		on Instant Breakfast-			nursing staff, and told them sh	ie	
					did not want an appointment made or her mother sent out.	She	
	•	carton of milk at lunch			verified this same decision aga		
	and dinner.				on 5/19/2014 with the DON.		
	4/9/14Weekly	weight on Sunday.			further compliance with regula		
		-			F 411, it is not necessary for		
	The resident was	also receiving a			Hoosier Village staff to assist		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155472 NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268
155472 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR
NAME OF PROVIDER OR SUPPLIER 9875 CHERRYLEAF DR
9875 CHERRYLEAF DR
HOOSIER VILLAGE INDIANAPOLIS, IN 46268
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DATE
THE REGULATOR OF ESCHELATION IN CONTRACTOR OF THE STATE O
Fentanyl (an opioid pain medication) Resident #9's daughter in making appointments. As in the past,
patch. appointments. As in the past, however, Hoosier Village will
make transportation
Other Physician orders included: arrangements to and from the
5/1/14"Mechanical soft/ground meat; dentist's office when the
thin liquids. Recommend 1 box appointment has been sent by the
Resource Breeze dailychart amount daughter. 1.Resident #9 was assessed for
consumed per MAR (Medication pain/discomfort or swallowing
Administration Record)poor P.O. (by issues when it was noticed that
mouth, oral), wound, weight down." she had lost a tooth. Resident did
not display any pain, or
discomfort and was changed to a
In an interview on 5/15/14 at 4:00 P.M., mechanical soft diet to assist with
LPN #5 indicated she knew about the chewing foods. Staff has discussed with daughter, who
makes all decisions in regards to
#12 was here at that time, and had written doctor visits, etc. and the
the Nurses progress note. daughter continues to want to
wait to have her mom sent to the
In an interview at that time, LPN #12 dentist.
indicated the family member came to her, 2. There were no other residents affected.
and told her the resident was a missing 3.In an effort to ensure ongoing
tooth. She and CNA #3 checked the compliance, the social services
resident's room, but could not find a designee will address with
teeth, which she thought was a little residents and families during
each care plan meeting dental
convices bear redaine and
part of the tooth in the resident's mouth- it looked liked the tooth had broken off that necessary dental work is
completed by maintaining an
She indicated the resident did not seem to appointment tracking log in each
be having any pain at that time. The residents chart in the care plan
family member vaguely mentioned section. The appointment tracking
making appointment with a dentist, but log will include Dental, Vision,
the nurse did not question her any further. Audiology and Podiatry appointments. (attachment #2).
The nurse did not do anything else. 4.As a means of quality
Because the resident was frequently assurance, the care plan
resistive to care, she did not try to coordinator will audit care plan

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155472	B. WING			05/16/	2014
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR		
HOOSIEI	R VILLAGE				APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The nurse indicated dental issue to So do any other follows of "Den of "Den of "Den of "Den of her own bridge." The intervere listed as: "I lay out supplies to some of her own of her own bridge."	lated 2/5/13, addressed a tal Care," and indicated this time. Resident has teeth as well as a partial erventions, dated 2/5/13, Monitor oral hygiene; for tooth brushing; le on follow-up care;			meeting notes and the appointment tracking log monthly to ensure that dental services has been offered and addressed with families. Resu of audits will be reviewed with Quality Assurance committee quarterly.	ılts	
F000505 SS=D	RESULTS The facility must p attending physicia Based on intervice the facility failed results to the Phy manner for 2 of 2 reporting accuch Physician. (Resi	n of the findings. ew and record review, to report accucheck visician in a timely 2 residents reviewed for eck results to the dent #10 and #15)	F000	0505	The facility is requesting a face face IDR for F505. The facility believes we have met the requirement of notifying the physician promptly for lab resu in this case finger stick blood sugars. Documentation shows that the physician was promptl notified and new orders were received for both resident #10 and resident #15. In all instant blood sugars were called to the physician, the nurse received a	ults, y ces e	06/11/2014

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Event ID:

V13I11

Facility ID: 000548

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPLE	TED
		155472		LDING		05/16/2	2014
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
1100015	D./// 1.4.0E				HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on 5/15/14 at 1:4	43 P.M. Diagnoses			return call, new orders were		
	included, but we	ere not limited to,			received and administered wit		
	1	and diabetes mellitus.			2-3 hours. The facility Medical		
	iny pergrycenna,	and diabetes memtas.			Director, Dr. Diane Healey		
	A 11D1 1.0	N			confirms that nursing staff noti		
	_	Monitoring Sheet" with			the physician or on call physic with the documented blood	ian	
	1	ndicated a blood sugar at			sugars in an appropriate time		
	6:00 A.M., of 31	1 for the resident.			frame.		
					1.Resident #10 had a blood		
	A Nurse's Note	dated 4/26/14 at 12:30			sugar of 311, results were call	ed	
		"Also, BS [blood sugar]			to the on call physician and ne	ew	
		rder given to give 6 units			orders were received and insu	lin	
		•			given. Resident #15 had a blo	od	
		bcutaneous] as was			sugar of 374 and the on call		
	scheduled for ac	cucheck of 300"			doctor was notified, orders we	re	
					received and insulin given.		
	A Physician's O	rder dated 4/26/14 at 5:30			2.There were no other reside	ents	
		'Give 6 units Novolog			affected 3.In an effort to ensure ongo	ina	
	insulin for BS of	_			compliance, a health center	""9	
		1 311			nurses mandatory in-service of	n l	
					6/3/14 and 6/10/14 included th		
	_	riew on 5/16/14 at 10:00			review of the physician call ord	ders	
	A.M., the Admir	nistrator indicated, LPN			for blood sugars, and to		
	#12 had contacte	ed the doctor, gotten			document in nurses notes whe		
	orders and had g	given the insulin for a			the physician was called, when	n	
	_	d sugar of 311 on 4/26/14			received return call and when		
	·	ne Administrator had			orders were received and		
		of a screenshot picture of			administered for finger stick bl sugars. Nurses will document	000	
	1	-			those residents that have routi	ine	
	· ·	cation Administration			blood sugars and insulin on th		
	·	ith the time LPN #12 had			nurses 24 hour report sheet. T		
	signed the insuli	n off as being			report sheet will be audited		
	administered.				weekly to ensure that nursing		
					staff is notifying the physician	of	
	The April 2014	Physician order recap			out of range blood sugars		
		sheet included, but were			promptly and that nurses note		
					reflect when calls to the physic		
		e following orders:			are made and when orders are	e	
	4/26/14Aspart	Insulin 100 units/ml			received.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPLE	
		155472	B. WIN	IG		05/16/2	2014
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLI EIER				HERRYLEAF DR		
HOOSIEI	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	,	e per sliding scale			4.As a means of quality assurance, the weekly audits v	a dill	
	Subcutaneous tw	-			be reviewed with the Quality	WIII	
	_	accucheck below 200.			Assurance Committee quarter	ly.	
	201-250=Give 4						
	251-300=Give 6						
	301-350=Give 8						
		necks twice daily 0600					
	(6:00 A.M.) and	1600 (4:00 P.M.) . Call					
	results < (below)) 70 or > (above) 300.					
	2. Resident #15	's record was reviewed					
		12 A.M. Diagnoses					
		ere not limited to, acute					
	-	onic kidney disease					
	Stage 3, and dial						
	Stage 3, and dia	betes memus.					
	A "Blood Sugar	Monitoring" sheet					
	indicated the res	ident had a blood sugar					
	of 360 on 4/24/1	4 at 11:00 A.M.					
	A Nurse's Note of	dated 4/24/14 at 12:00					
	P.M., indicated t	the resident's accucheck					
	was 360 and the	Nurse Practitioner was					
	notified and a ne	ew order was given.					
	_	Monitoring" sheet					
		ident had a blood sugar					
	of 374 on 4/27/1	4 at 11:00 A.M.					
	A Nursala Nota	dated 4/27/14 at 1:15					
		the doctor was notified					
		for 8 units of Novolog of					
	insulin now was	received one time only.					

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155472			A. BUII	DING	00	COMPL 05/16/	
		155472	B. WIN			05/16/	2014
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HOOSIFI	R VILLAGE				HERRYLEAF DR APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID ID	7 ti - OZIO, IIV 10200		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	A Physician's or	der dated for 4/27/14 at					
	1:30 P.M., indica	ated "Give 8 units					
	Novolog insulin	@ [at] this time for					
	accucheck of 37	4-1 x [time] only."					
	_	Monitoring" sheet					
		ident had a blood sugar					
	of 457 on 5/2/14	at 4:00 P.M.					
	A 3.1 3.1	1 . 1.7/2/14 7.20					
		lated 5/2/14 at 5:30					
		'Accucheck 456 reported					
	[new order] rece	se Practitioner) N.O.					
	l liew order] rece	iveu.					
	A Physician's or	der dated 5/2/14 at 5:30					
	1	'Increase levemir [Insulin					
	· · · · · · · · · · · · · · · · · · ·	2 units q [every] am."					
	The April 2014 I	Physician order recap					
	sheet included, b	out were not limited to					
	the following or	ders:					
	4/8/14Accuche	ecks three times a day					
	before meals. R	ecord on BS (Blood					
	Sugar) flowshee	t. Call MD if BS < 70 or					
	>350.						
		ecks three times a day					
		ocument results on the					
		MAR. Call with results					
	below <70 or >4	50.					
	_ ~	iew on 5/15/14 at 4:40					
		or of Nursing indicated					
	_	length of time a nurse					
	was to wait to no	otify a Physician a blood					

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Event ID:

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If continuation sheet Page 40 of 69

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155472	A. BUILDING B. WING		05/16/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		CHERRYLEAF DR	
HOOSIEI	R VILLAGE			NAPOLIS, IN 46268	
(X4) ID	SHMMARVS	STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		below or above the call			
		not to be four hours.			
	parameters was	not to be four nours.			
	2.1.40(.)(2)				
	3.1-49(e)(2)				
F009999					
1 000000					
	3.1-3 RESIDEN	NT RIGHTS	F009999	1.Resident #114 plan of care	06/13/2014
				has been modified from receiv	
	(v)(1) A residen	t has a right to the		assistance with showers to	
		leside and receive		receiving assistance with bed	4
	• • •			baths. Although Resident #11-was changed from a shower to	
		acility with reasonable		bed bath, she continues to be	Ja
		s of the individual's needs		agitated with any direct care	
	-	, except when the health		provided, including but not lim	ited
	_	individual or other		to bed baths. Of note, there are	
	residents would	be endangered.		several other nursing notes in	
				residents chart that reflect this resident becoming agitated no	
	This rule was no	ot met as evidenced by:		only with showers but with all	
				other direct care provided due	to
		iew and record review,		her late stage dementia. Staff	
	the facility faile	d to offer other bathing		continues to use several	
	options to 1 of 5	residents reviewed for		interventions to minimize her	
	bathing choices	in a sample of 6.		agitation such as using a calm voice, redirection, and	
	(Resident #114)			re-approaching at a later time.	
				2.There were no other residence	
	Findings include	e:		affected.	
	<i>3.</i>			3.In an effort to ensure ongo	~
	The record revie	ew for Resident #114 was		compliance, a mandatory nurs in-service addressing resident	
		/14/14 at 11:00 A.M.		rights and bathing choices will	
		ded, but were not limited		conducted on 6/3/14 and 6/10	
	_			CNAS are trained to notify the	
	to, dementia wit	·		nurse immediately if a residen	t
	osteoarthritis, ai	nd high blood pressure.		becomes agitated. CNA's are	
				responsible for filling out a	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a	00	COMPL	ETED
		155472	A. BUII			05/16/	/2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
HOOSIE					HERRYLEAF DR		
HUUSIE	R VILLAGE			INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		vice Documentation for			bathing/shower sheet each tir	ne	
	MDS" (Minimu	m Data Set) assessment,			they assist a resident with a		
	dated 6/25/13, indicated the resident was				shower or bath. The bathing/shower sheet has been	\n	
	· ·	nted x 1. She has			updated to include alternative		
		er short term memory, as			offered as well as any behavior		
	1				exhibited during bathing. A nu		
		recall questions writer			will weekly review bathing she	eets	
	_	Resident is able to			to ensure that staff are followi	•	
	_	times, but due to			residents plan of care for bath	ing	
		word finding this can be			preferences.		
	difficult. She ca	in also understand others,			4.As a means of quality		
	but due to cogni	tive impairment may			assurance, audits will be reviewed with the Quality		
	misconstrue wha	at is being said" The			Assurance Committee quarter	٦v	
		marked as incomplete			Quality of Care	.,.	
		being unable to answer			1.Resident #114 was		
		•			re-evaluated and by the nurse	;	
	questions approp	oriately.			practitioner and an order was		
					received for scheduled Tylend		
		notes from May 2013			Nurses will be in-serviced to c	lo a	
	through May 20	14 indicated the resident			pain assessment on resident	ina	
	displayed behav	iors as follows:			#114 whenever she is display behaviors such as agitation the	-	
					could be an indication of pain.		
	7/26/13"Resi	ident was given shower			2.There are no other reside		
		ent screamed the entire			affected.		
		nt uncooperative"			3.To ensure ongoing		
		ceived shower this shift			compliance all nurses were		
					in-serviced on 6/3/14 and 6/10		
		nides. Very combative			regarding monitoring for signs		
	during shower h	itting and scratching"			and symptoms of pain, using pain assessment form, and to		
	11/23/13"Re	sident was combative			report and follow up with the		
	and screaming d	uring shower, yelling and			physician. In addition, the soc	ial	
	cursing"	· -			services designee will audit al		
	12/3/13"Resi	ident was verv			new behavioral referral sheets		
	combative, hittir				weekly to ensure that the resi	dent	
	screaming durin				has been assessed for pain.		
		C			4.As a means of quality		
		ident was given a shower			assurance, the weekly audits	WIII	
	I this A.M. by this	s nurse and Director of			be reviewed with the quality		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI 111	DINC	00	COMPL	ETED
		155472		LDING		05/16/	2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	L Comment			HERRYLEAF DR		
ПООСІЕІ	R VILLAGE				IAPOLIS, IN 46268		
HOOSIEI	R VILLAGE			INDIAN	IAPOLIS, IN 40200		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Nursing (DoN)	due to concerns raised by			assurance committee quarterl	· .	
	a night shift CN	A regarding			Drug Therapy The rule of each		
	combativeness o	f resident. The CNA had			resident's drug regimen must free from unnecessary drugs.		
	received a scrate	h on her arm as a result			unnecessary drug is any drug	AII	
	of the resident sy				when used without adequate		
		oited short bursts of			indications for its use. This rule	e	
					was met by the facility and the		
	l · -	ng but was consistently			facility is requesting an IDR fo	r	
		sured of her safety. She			the following reasons.The		
		or twice but did not			indication for the antipsychotic	;	
	connect with eitl	ner staff nor did she			medication is very clearly	:!	
	cause harm to he	erself. CNAs will be			indicated in the residents med chart: Dementia with behavior		
	given some exan	nples/suggestions for			disturbances. In The Nurse	aı	
	showering this re				Practitioners and the Medical		
		sident calm most of day			Directors notes the diagnosis	for	
		·			this resident is SDAT with BPS		
		s during shower-hitting			(Senile Dementia Alzheimer's		
	biting and screar	•			Type with Behavioral and		
	1/22/14"Rec	eived shower this shift,			Psychological Symptoms of		
	aide instructed to	o slowly explain tasks			Dementia). Resident #114 was	S	
	before performing	ng them, not effective			started on Risperdal (an antipsychotic) on 6/8/14 when	che	
	cursing at staff a	nd hitting calling the			was transferred to the health	SIIC	
	aide names"	2 2			center after her husband was	no	
		ved shower this shift,			longer able to care for her in the		
		· · · · · · · · · · · · · · · · · · ·			residential building due to		
		esident screaming during			worsening dementia with		
	care"				paranoia and behavioral chan	-	
		dent combative during			Staff in the Residential building	~ I	
	shower today. H	litting and cursing at			attempted several non-medical interventions to assist the	11	
	staff"				resident's husband with her ca	are	
	4/12/14"Resi	dent received shower			that were unsuccessful.		
	this morning and	I had an episode of			Interventions included bringing	,	
	crying"				her to the health center for gro		
	crying				activities, assisting her son to		
	The MDC (M::::	mayor Data Cat)			come in and interact with her,		
	The MDS (Minimum Data Set)				redirection especially when sh	е	
		d ** indicated the			was upset with her husband,		
	resident was una	ble to answer regarding			validation of her feelings, and		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPL	ETED
		155472	A. BUIL B. WING			05/16/	2014
			D. WING	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			HERRYLEAF DR		
HOOSIE	R VILLAGE				IAPOLIS, IN 46268		
ПООЗІЕ	R VILLAGE			INDIAN	IAPOLIS, IN 40200		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	her preferences	for bathing.			ADL assistance. Both the soc	ial	
					services designee and the		
	During an interv	view on 5/15/14 at 4:40			pharmacy consultant monitor		
	_	nistrator and DoN			residents on Anti-psychotics. Every effort is made to attempt		
		a resident became			dose reduce. Of note, the faci		
					is well within the requirements	-	
		ed to yell or refused a			dose reduction for this resider		
	shower after it v	vas started the staff, was			The facility is requesting a fa		
	to stop the show	er and attempt an			to face IDR for 9999- Drug		
	alternative way	to bathe the resident. The			therapyThe rule was met for t	he	
	DoN indicated t	he CNAs have been			following reasons:		
		thing residents, and were			The indication for the		
		_			antipsychotic medication is ve		
		"Bathing without a			clearly indicated in resident #	114	
		truction tool for bathing			medical chart. In The Nurse Practitioners and the Medical		
	residents withou	t the resident being			Directors notes the diagnosis	for	
	combative. The	DoN indicated if the			this resident is SDAT with BP		
	resident was una	able to say what their			(Senile Dementia Alzheimer's		
		e, due to dementia, they			Type with Behavioral and		
	_	resident a shower.			Psychological Symptoms of		
	would give the i	esident d shower.			Dementia) or Dementia with		
					behavioral disturbances.The		
	_	y information regarding			facility attempted several		
		f bathing attempted for			non-medical interventions price		
	Resident #114 w	vas requested at that time.			the start of the anti-psychotic.	Of	
					note, Resident #114 was in a	iith.	
	As of the exit co	onference on 5/16/14 at			Residential apartment living wher husband who was providing		
	4:15 P.M., no fu				care for her at the time that	ig .	
	1	umentation was provided			behaviors started. Staff in the		
		umentation was provided			Residential building did attem		
	for review				several non-medical intervent	ions	
					to assist Mr. Snider with her c	are	
	3.1-3(v)(1)				that were unsuccessful.		
					Interventions included bringing	•	
					her to the health center for gro	•	
	3.1-37 QUALIT	Y OF CARE			activities, her son came in sev		
	J.1-37 QUALII	1 Of CINE			times to sit with her, redirection		
					especially when she was upse		
	(a) Each residen	t must receive and the			with her husband, validation of)	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		n c	00	COMPL	ETED
		155472	A. BUILD	DING		05/16/	
		1.5	B. WING			33, 10,	== · ·
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
			1		HERRYLEAF DR		
HOOSIEI	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	facility must pro	ovide the necessary care			her feelings, and ADL assista	nce.	
	and services to a	attain or maintain the			Resident #114 husband		
	highest practica	ble physical, mental, and			continued to have difficulty ca for his wife due to worsening	ring	
		ell-being in accordance			dementia with paranoia and		
		ehensive assessment and			behavioral changes and on 6/	8/14	
	_	mensive assessment and			agreed to have her transferred		
	care plan.				the health center for		
					comprehensive care. The		
	This rule was no	ot met as evidenced by:			antipsychotic medication,		
					Risperdal was started a few h	ours	
	Based on interv	iew and record review,			after she was admitted to the		
	the facility faile	d to assess and treat the			health center as behaviors		
		nt with dementia, for 1 of			continued to escalate despite staff interventions. Both the		
		ewed for pain in a sample			social services designee and	tha	
		•			pharmacy consultant monitor	uic	
	of 6. (Resident	#114)			residents on Anti-psychotics.		
					Every effort is made to attempt	ot to	
	Findings include	e:			dose reduce. Of note, accordi		
					to the regulations addressing		
	The record revie	ew for Resident #114 was			antipsychotic medication and		
	completed on 5/	/14/14 at 11:00 A.M.			gradual dose reductions, the		
		ided, but were not limited			facility is well within the		
	1 –				requirements for dose reduction		
	to, dementia wit				for this resident. 1.Resident # was admitted to the health ce		
	osteoarthritis, ai	nd high blood pressure.			on 6/6/13 with a diagnosis of	i itei	
					SDAT with BPSD and with		
	The "Social Ser	vice Documentation for			physician orders for Risperda	l.	
	MDS" (Minimu	m Data Set) assessment,			The resident will be monitored		
	`	ndicated the resident was			response and continued need	of	
	•	ented x 1. She has			Risperdal. A physician order v		
					received for a dose reduction		
	<u> </u>	ner short term memory, as			the Risperdal on 5/29/14.2. The	nere	
	she is unable to recall questions writer				were no other residents	.:II	
	was asking herResident is able to				affected.3. Licensed nurses w be in-serviced on 6/23/14	/III	
	express needs at times, but due to				regarding assessing residents	for	
	inattention and	word finding this can be			unnecessary medications,	, 101	
		an also understand others,			adverse consequences of		
		itive impairment may			medications, progress toward	S	
	i bui uuc io coem	itivo miidaminont mav					1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155472 05/16/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9875 CHERRYLEAF DR HOOSIER VILLAGE INDIANAPOLIS. IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG therapeutic goals, gradual dose misconstrue what is being said...." The reductions, and physician assessment was marked as incomplete notification. The social service due to resident being unable to answer designee will identify all residents questions appropriately. receiving psychoactive medications on the behavior monitoring sheets to track The resident was in the assisted living specific targeted behaviors and portion of facility until 6/8/13. She was will audit the nurses living with her husband who was unable documentation weekly for needed to care for her at that time. The changes. In addition, the consultant pharmacist will audit information for medications provided by each resident's medication the resident's family physician indicated regimen monthly for upon admission to the Health Care unit, recommendations. The interdisciplinary team will review the resident had been receiving Celebrex each resident's medication 200 milligrams (a medication for regime during the care plan arthritis) twice daily as needed in June of review, and the Physician or 2012 and March of 2013. Nurse Practitioner will review each resident's medications at least quarterly.4. The pharmacy The instructions for a document titled consultant and social services "Pain Assessment Tool" indicated the designee audits will be reviewed following: "Ask the resident to rate their at quarterly Quality Assurance meetingsFood. The facility has own pain, if the resident is able to do so, one kitchen that services the using a 0 to 10 numerical rating scale. 0 entire health center. The indicates the absence of pain and 10 residents that are in the skilled represents the most intense pain possible. unit and the residents that are in Date and time the appropriate column on the non-certified beds receive food service and meals from the the table below and record the resident same kitchen. The facility was response in the PAIN SCORE section on cited twice F371 and F9999(food) the table and sign. If the resident is for the same findings by the unable to verbally rate their own pain, the surveyors. The Plan of Correction is the same for both. A nurse observes the resident and rates their 1.On 5/12/14, the "well" pans pain based on the FLACC (Face, Legs, with debris & wet were removed Activity, Cry, Consolability) scale below. from use and taken to the dish Date and time a column, assess each of room for cleaning and sanitizing. 2. The well pan was removed the 5 areas with a 0, 1, or 2 response and

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155472	B. WIN			05/16/	2014
		1	J. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			HERRYLEAF DR		
HOOSIE	R VILLAGE				APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ACC score. Record the			from service, therefore no residents were affected.		
	total FLACC sco	ore in the PAIN SCORE			3.In an effort to ensure ongo	ina	
	on the table and	sign."			compliance, all Health Center	"ig	
					Dining Services Employees wi	ill	
	The FLACC por	tion of the assessment			be re-trained per policy on pro		
	had the followin				cleaning, air-drying, and invert		
	10110 11111	<i>G</i> =			storage of pans per policy. Sta	aff	
	Face-				in-service to be conducted on		
		avaraggion or smile			6/4/14, 6/11/14, and 6/12/14. Utility staff will ensure this		
	_	expression or smile.			practice is followed on a		
	1-Occasional gri				consistent basis by the daily U	Itility	
	^	onstant quivering chin,			Staff Checklist. Weekly randor		
	clenched jaw.				visual checks will be conducte	d	
					by a dietary manager.		
	Legs-				4.As a means of quality		
	0- normal position	on or relaxed			assurance, the weekly visual audits done by dietary		
	1- uneasy, restle				management will be reviewed		
	2- Kicking or leg				with the Quality assurance		
		S r			committee on a quarterly basis	S.	
	Activity-				В		
	1	normal position, moves			1.On 5/12/14 the black spill i	in	
		normai position, moves			the oven was cleaned. 2.The spill in the oven was		
	easily	10:11			immediately cleaned, therefore	ء ا	
	1 2	nifting back and forth,			there were no residents affect		
	tense-				3.In an effort to ensure ongo		
	2- Arched, rigid	or jerking			compliance, all Dietary Health		
					Center Production Employees		
	Cry-				be re-trained per policy, on pro		
	0- No cry (awak	e or asleep)			oven & equipment cleaning. S in-service to be conducted on	ldII	
	1- Moans or wh	impers, occasional			6/4/14, 6/11/14, and 6/12/14.		
	complaint	_			Random weekly visual checks	will	
	^	lv. screams or sobs.			be conducted by a dietary		
	2- Crying steadily, screams or sobs, frequent complaints				manager to ensure proper ove		
	inequent compla	******			and equipment cleaning is bei	ng	
	Concolohility				done.		
	Consolability	1			4.As a means of quality assurance, the weekly visual		
	0- Constant relax	xea			accuration, the weekly visual		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	V DIIII	DINC	00	COMPLET	ΓED
		155472	A. BUIL B. WING			05/16/2	014
		<u>I</u>	D. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			HERRYLEAF DR		
HOOSIE	R VILLAGE				IAPOLIS, IN 46268		
	. VILLAGE				IAI OLIO, IIN 40200		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	occasional touching,			audits done by dietary	,	
	hugging, or beir	ng talked to distractible			management will be reviewed with the Quality assurance	,	
	2- Difficult to console or comfort				committee quarterly.		
					C.		
	The resident's "	Pain Assessment Tool"			1.The sanitation bucket was	s	
	indicated the fol				immediately removed and		
	mulcated the 10	nowing.			replaced with sanitizing soluti	on	
	6/10/10 "	1 1			at 200 ppm.		
		nplaints bilateral knee			2.The sanitation solution wa		
		rate PRN Tylenol			replaced with solution that wa		
	given"				200ppm, therefore no resider were affected.	แร	
	9/28/13- under t	the columns for the			3.In an effort to ensure ong	oina	
	FLACC section	s all indicated "0" and the			compliance, all Health Center		
	Total FLACC S				Dining Services Employees v		
		the columns for the			be re-trained per policy on pre		
		s all indicated "0" and the			use of sanitizing solution and		
					frequency of changing sanita	tion	
		core was "0. Comments			solution per policy. Staff		
		signs or symptoms of			in-service to be conducted or		
	pain/discomfort	"			6/4/14, 6/11/14, and 6/12/14. Health Center Dining Service		
					Employees and management		
	The Nurses Not	es, dated from June 2013			ensure the sanitation solution		
	through April 20	014, indicated the			being changed per policy as		
	following:				evidenced on the daily Utility		
					Checklist. Random weekly vis		
	6/8/13 Comple	aints of bilateral knee			checks will be conducted by a		
					dietary manager to ensure the	e	
	_	Tylenol given and taken.			sanitizing solution has been changed out and at the		
		screaming, yelling out			appropriate concentration.		
	`	rtified Nursing Aide)			4.As a means of quality		
	assist with ADL	(Activities of Daily			assurance, the weekly visual		
	Living)				audits done by dietary		
	7/6/13 "abru	pt periods of weeping and			management will be reviewed	t l	
	agitation" 7/7/13"11:30 P.M. resident complaining of pain to knees"				with the Quality assurance	.	
					committee on an ongoing bas	SIS	
					quarterly. D.		
		_			1.The eleven ice creams we	ere	
	//23/13"resi	dent kicked and yelled			1. The cleven ice creams wi		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a	00	COMPL	ETED
		155472	A. BUII			05/16/	/2014
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1			
ПООСІГ	R VILLAGE				HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	during morning	care"			immediately discarded.		
	8/9/13"nurse	notified by aide that			2. The eleven ice creams we		
	resident had redi	ness on her lower			immediately discarded therefore		
	buttocks and nur	rse observed red,			there were no residents affected. 3.All Health Center Dining		
		esident combative with			Services Employees will be		
	care"				re-trained on proper covering,		
		ont arring on and off all			labeling, and dating of produc	ts	
		ent crying on and off all			per policy. Staff re-training to		
	1	attempt to administer			conducted on 6/4/14, 6/11/14,		
		re, occasionally effective,			and 6/12/14. Dining Services		
	This afternoon d	uring care the resident			and management will ensure to practice is followed on a	INIS	
	was screaming '	oh my god, stop it' staff			consistent basis by the daily		
	explained to resi	dent what they were			Dining Staff Checklist. Randon	m	
	_	resident began to name			weekly visual checks will be		
	call and cuss and	•			conducted by a dietary manag	ger	
		esident had episodes of			to ensure staff are coving,		
		•			labeling and dating products		
		anyone hurt my family'			appropriately.		
	at CNA"				4.As a means of quality		
		sident resisting care			assurance, the weekly visual audits done by dietary		
	yelling screamin	g do not want to lay			management will be reviewed		
	down. it took 2	staff to put her back in			with the Quality assurance		
	bed"				committee ongoing quarterly.		
	1/13/14 "Aid	les instructed to explain			E.		
		to completion, this was			1.The Manitowac ice machin		
		ile giving hygiene care.,			are designed with a ledge insi		
					the bin that holds the scoop, v not allowing it to touch the ice		
		rsing and became			This is consistent with the		
	tearful"				department policy.		
		sident cursing and hitting			2.There were no residents		
	and yelling at sta	aff. Aides instructed to			affected.		
	approach resider	nt in calm manner when			3.In an effort to ensure ongo	-	
	performing ADI	and to explain process,			compliance, all Health Center		
	this was not effe				Dining Services Employees w		
		sident yelling and			be re-trained on proper storag		
		g care, occasional crying			the ice scoop. Staff re-training be conducted on 6/4/14, 6/11/		
	episode noted"				and 6/12/14. Dining Services		
	pisoue noted"		1		1 5		Ī

NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE STREET ADDRESS. CITY. STATE. ZIP CODE 9875 CHERRYLEAF DR 9875 CHERRYLEAF DR 100 100 100 100 100 100 100 100 100 10	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MIST BE PRECEDED BY FILL TAG PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY (PACH DEFICIENCY MIST BE PRECEDED BY FILL REGULATORY OR LISC IDENTIFYING INFORMATION) 2/28/14"resident mad a crying spell earlier this evening" 4/5/14"resident uncooperative and crying during care. no signs and symptoms of pain resident does not verbalize pain at this time" 5/8/14"resident combative during care, seratching at CNAdistraction and re-direction unsuccessful" The MAR (Medication Administration Record) listed the following physician orders for medications: 6/4/13Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13Treeze It" gel to both knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/2/14Treeze It" gel to both knees cach shift.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING		LETED	
NAMOSIER VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRY TAG PROVIDERS PLANOF CORRECTION FORCES, IN 46268 PREPRY TAG PROVIDERS PLANOF CORRECTION FORCES, IN 462714—"resident had a crying spell earlier this evening" 4/5/14"resident uncooperative and crying during care. no signs and symptoms of pain resident does not verbalize pain at this time" 5/8/14"Resident combative during care. scratching at CNAdistraction and re-direction unsuccessful" The MAR (Medication Administration Record) listed the following physician orders for medications: 6/4/13Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13-"Freeze It" gel to both knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to the given by mouth three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily an eneeded for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily an eneeded for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily an eneeded for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily an eneeded for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily and for an eneeded, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14, Utility staff and management will ensure this practice is followed on a consistent tasis by the daily complexed to be prevented to the conducted on 6/4/13, 6/11/14, and 6/12/14, Utility staff and management wille			155472				05/16	/2014
HOOSIER VILLAGE INDIANAPOLIS, IN 46288 IN 45, IN 46288 IN 46, IN 4	NAME OF P	DOMDED OF CLIDE IE	D.		STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
SUMMARY STATEMENT OF DEFICIENCIES PREFIX CALL PREFIX TAG PREFIX CALL PREFIX TAG PREFIX CALL PREFIX PREFIX TAG TAG PREFIX TAG TAG PREFIX TAG TAG PREFIX TAG	NAME OF P	KOVIDEK OK SUPPLIE	K		9875 C	HERRYLEAF DR		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2/28/14"resident had a crying spell earlier this evening" 4/5/14"resident uncooperative and crying during care. no signs and symptoms of pain resident does not verbalize pain at this time" 5/8/14 "Resident combative during care. scratching at CNAdistraction and re-direction unsuccessful" The MAR (Medication Administration Record) listed the following physician orders for medications: 6/4/13Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13"Freeze It" gel to both knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift.		R VILLAGE			INDIAN	IAPOLIS, IN 46268		
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storage policy. 5/8/14 "Resident combative during care. scratching at CNAdistraction and re-direction unsuccessful" The MAR (Medication Administration Record) listed the following physician orders for medications for arthritis and pain medications: 6/4/13Acctaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13"Freeze It" gel to both knees three times daily. 7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. storage policy. 4.As a means of quality assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. F. 1.The spot of debris observed on the floor underneath the food rack in the dry storage area was estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2.There were no residents affected. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		symptoms of pa	in resident does not			-	ger	
5/8/14 "Resident combative during care. scratching at CNAdistraction and re-direction unsuccessful" The MAR (Medication Administration Record) listed the following physician orders for medications for arthritis and pain medications: 6/4/13Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13Freeze It" gel to both knees three times daily. 7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. 5/8/14 "In Resident combative during assurance, the weekly visual audits done by dietary management will be reviewed with the Quality assurance committee quarterly. F. 1. The spot of debris observed on the floor underneath the food rack in the dry storage area was estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2. There were no residents affected. 3. In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		verbalize pain a	t this time"					
care. scratching at CNAdistraction and re-direction unsuccessful" The MAR (Medication Administration Record) listed the following physician orders for medications for arthritis and pain medications: 6/4/13Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13"Freeze It" gel to both knees three times daily. 7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. 4.7. A management will be reviewed with the Quality assurance committee quarterly. F. 1. The spot of debris observed on the floor underneath the food rack in the dry storage area was estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2. There were no residents affected. 3. In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		•						
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orders for medications for arthritis and pain medications: 6/4/13Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13"Freeze It" gel to both knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. 1.The spot of debris observed on the floor underneath the food rack in the dry storage area was estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2.There were no residents affected. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		`						
pain medications: 6/4/13Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13"Freeze It" gel to both knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. on the floor underneath the food rack in the dry storage area was estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2.There were no residents affected. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		· ·						
rack in the dry storage area was estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2. There were no residents affected. 3. In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily						•		
6/4/13Acetaminophen 325 milligrams 2 tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13"Freeze It" gel to both knees three times daily. 7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. estimated to be approximately 2" in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2. There were no residents affected. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		pain medication	s:					
tablets every 4 hours as needed for pain and Hydraflexin 2 capsules daily for joint supplement. 6/13/13"Freeze It" gel to both knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. in diameter. The spot was immediately cleaned and appeared to be jelly that had dropped. 2. There were no residents affected. 3. In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily								
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supplement. 6/13/13"Freeze It" gel to both knees three times daily. 7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. dropped. 2.There were no residents affected. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		tablets every 4 l	nours as needed for pain			_		
supplement. 6/13/13"Freeze It" gel to both knees three times daily. 7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. 2.There were no residents affected. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		and Hydraflexir	2 capsules daily for joint					
6/13/13"Freeze It" gel to both knees three times daily. 7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. 2. There were no residents affected. 3. In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		supplement.				1 7		
three times daily. 7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. 3.In an effort to ensure ongoing compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily			e It" gel to both knees					
7/11/13 Apply ice to knees three times daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. compliance, All Health Center Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily							oing	
daily as needed for pain; Tylenol 325 milligrams, 2 tablets to be given by mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. Dining Services Employees will be re-trained per policy on proper daily and/or as needed, sweeping and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily			•					
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mouth three times daily for 7 days for knee pain. 1/21/14"Freeze It" gel to both knees each shift. and mopping of kitchen floors. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily			• •					
knee pain. 1/21/14"Freeze It" gel to both knees each shift. Staff re-training to be conducted on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		_	- ·					
on 6/4/14, 6/11/14, and 6/12/14. Utility staff and management will ensure this practice is followed on a consistent basis by the daily			les daily for / days for					
each shift. Utility staff and management will ensure this practice is followed on a consistent basis by the daily		•						
each shift. ensure this practice is followed on a consistent basis by the daily			e It" gel to both knees					
Liver of the liver and the liver by the live		each shift.				ensure this practice is followed	ed on	
I THERE OF A LITTLE DESCRIPTION								
		The Tylenol 32:	5 milligrams 2 tablets			Utility Staff Checklist. Randor	m	
every 4 hours as needed for pain was not weekly visual checks will be conducted by a dietary manager		every 4 hours as	s needed for pain was not				gor	
documented as being given from July conducted by a dietary manager to ensure routine cleaning is		-	_				yeı	
2013 through May 2014. being completed.						_		
4.As a means of quality		<u>G</u>	•					

PRINTED: 09/16/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155472	B. WIN	IG		05/16/	2014
NAME OF B	DOLUDED OD GUDDU IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	C		9875 CI	HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		on 5/15/14 at 4:30 P.M.,			assurance, the weekly random visual audits done by dietary	1	
		Nursing (DoN) indicated			management will be reviewed		
	Resident #114 w	vas able to verbalize her			with the Quality assurance		
	pain to staff, and	l that the pain			committee quarterly.		
	assessments indi	icated the resident had no					
	pain. She also in	ndicated the physician					
	had ordered the	resident pain medication					
	as well as PRN ((as needed) Tylenol for					
	pain.						
	On 5/16/14 at 1:	45 P.M., the Staff					
	Development Co	pordinator provided the					
	pain policy, date	ed 1/30/12. The policy					
	indicated, "Thi	rough systematic					
		vill be identified,					
		bal or non-verbal					
	•	tervention (medication					
	•	tion) will be initiated and					
		il pain is managed to the					
		on of the resident, or (in					
		ognitively impaired or					
		ent) until factors					
		n have subsided"					
	marcan ve or pur						
	3.1-37(a)						
	- / / (~)						
	3.1-48-(a) DRU	G THERAPY					
	` ′	t's drug regimen must be					
	` '	essary drugs. An					
		g is any drug when used					
		e indications for its use.					
	out aacquatt						
	This rule was no	ot met as evidenced by:					

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Event ID:

V13I11

Facility ID: 000548

If continuation sheet

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	OF CORRECTION IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/16/2014			
	PROVIDER OR SUPPLIER R VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION			
	Based on interview and record review, the facility failed to attempt non-medical interventions prior to the start of an anti-psychotic medication, and failed to reduce or discontinue use of a antipsychotic medication when a resident was not displaying psychotic behaviors; for 1 of 5 residents reviewed for unnecessary drugs in a sample of 6. (Resident #114) Findings include: The record review for Resident #114 was completed on 5/14/14 at 11:00 A.M. Diagnoses included, but were not limited to, dementia with behaviors, osteoarthritis, and high blood pressure. The resident was in the assisted living portion of facility until 6/8/13. She was living with her husband who was unable to care for her at that time as the resident was increasingly incontinent of urine, would become agitated when assisted with toileting and not cooperative with spouse. On 6/8/13 the resident was taken from Assisted Living apartment and moved to the Health Center. After being brought to the Heath Center, the resident displayed several behaviors. A Nurses Notes entry, dated 6/8/13,						

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PRINTED: 09/16/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	OO	(X3) DATE	
AND PLAN	OF CORRECTION			LDING	00	COMPL 05/16	
		155472	B. WIN			05/16	2014
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
HOOSIE	R VILLAGE				HERRYLEAF DR APOLIS, IN 46268		
	1			<u> </u>	Al OLIO, IN 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	indicated the fol	•		1710	<u> </u>		DATE
	indicated the for	lowing.					
	7:00 A M"Cal	l from husband to report					
		creased hostility towards					
		is back asleep but that					
		ostilely has increased and					
	_	stent which is not her					
	norm."	stent which is not her					
	8:00 A.M "Hu	sband called to report					
	wife awake, con	tinuing with agitation.					
	Resident upset w	with husband for the way					
	_	ting their son and her					
	father."	_					
	9:40 A.M"Res	sident openly agitated					
	towards husband	l when she saw him at					
	dining room tabl	leResident stated then					
		to eat breakfast and was					
	derisive of husba	and as we passed him in					
	apartment speak	ing vaguely of other men					
	she should have	been with and calling					
	him a 'dumb ass'	after leaving apartment."					
	12:00 P.M"Ne	ew admit from assisted					
	livingresident	very agitated and irritable					
	_	ing and yelling for her					
	_	to visit and was agreeable					
	in going to room	with resident."					
		ysician called and was					
		dent's behaviors and an					
	order was receiv	red for Risperdal."					
		ident complaining of					
		in and PRN Tylenol					
	-	in halls looking for son,					
	_	o visit resident was in					
	good spirits."						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL	
		155472	B. WIN	G		05/16/	2014
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	D. ///				HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENC!)		DATE
	_	perdal delivered and					
	_	doing well with 1:1					
	care."						
	Th. "C: 1 C	in December in Com					
		vice Documentation for					
	`	m Data Set) assessment,					
	· · · · · · · · · · · · · · · · · · ·	dicated the resident was,					
		nted x 1. She has					
	1	er short term memory, as					
		recall questions writer					
	_	Resident is able to					
	_	times, but due to					
		vord finding this can be					
		n also understand others,					
	1	rive impairment may					
		t is being said" The					
		marked as incomplete					
		eing unable to answer					
		oriatelyDiscussed					
	~	nentia and psychotic					
		ed family member with					
	dementia process						
		esident had become upset					
	_	that staff are "hitting					
	-	The family member					
		in past did hit on the					
	_	parents were younger					
	and the resident	got her fired"					
		1					
		sychoactive Drug					
	1	ecord," was used to track					
		yed by a resident. The					
		pered behaviors, used to					
	select the display	ved behavior, and a key					

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PRINTED: 09/16/2014 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPI 05/16	LETED
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268		-2011
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO) BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION) enter the number of "C" indicating		TAG	DEFICIENCY)		DATE
	"Continuous."	·					
	the resident was	receiving Risperdal 0.5 lentified behaviors of "3.					
	_	king," "5. Paranoia," and					
	The resident's m indicated the following	onthly flow records lowing:					
	11th, 12th, 20th,	ndicated no episodes of					
	specific descript the night shift, a two episodes on	episode of "paranoia" (no ion was documented) on and continuous on 7/5; 7/8; one episode on isode on 7/21/12					
	August 2013th "12. Other" chan "refusing care."	isode on 7/31/13. e behavior tracking for ged from "yelling out" to There was no f any paranoia episodes.					
	September 2013 documentation of	There was no f any paranoia episodes.					
	October 2013 7 documentation o	There was no f any paranoia episodes.					

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Event ID:

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Facility ID: 000548

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		155472	A. BUI B. WIN	LDING IG		05/16/	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	{		9875 CH	HERRYLEAF DR		
HOOSIE	R VILLAGE			INDIAN	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1110	AEGOZATORI OR	EDG IDENTIFICATION OF THE OTHER PROPERTY.		1110			5.112
	November 2013	There were "plus" signs					
		ler paranoia on 11/8,					
	11/9, 11/10, 11/1	11, 11/12, 11/16, 11/17,					
	11/22, 11/23, 11	/27, for the day shift.					
		There was a "plus" sign					
	documented und	ler paranoia on 12/25.					
	January 2014 T	here were "plus" signs					
	· ·	ler paranoia on 1/2.					
	documented und	ici paranoia on 1/2.					
	February 2014	There was no					
	· ·	of any paranoid behavior.					
	April 2014The	re was no documentation					
	of any paranoid	behavior.					
		es in November, 2013,					
		lowing behaviors:					
		incooperative with care					
	1	ggressive with care taker.					
		cursed and screamed at					
	CNA's during ca						
		screaming during AM					
	care.	valling at staff and					
		yelling at staff and as well as crying during					
	care.	as wen as crying during					
		combative during					
	shower.	comoanve during					
	11/16Resident	continues to be					
	combative with						
		combative, yelling, and					
	11,17 Resident						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155472	B. WIN	G		05/16/2	2014
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			9875 CH	HERRYLEAF DR		
	R VILLAGE				APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	cussing during c						
		combative during care					
	today yelling and	_					
	throughout care.						
	11/23Resident	combative and					
	screaming durin	g shower, yelling and					
	cursing.						
	11/27Resident	combative and cursing at					
	CNA's during ca	are.					
	12/25Resident	was aggressive during					
	care and had epi	sode of crying before					
	lunch.	<i>y</i>					
		t aggressive, yelling, and					
	crying during ca						
	The physician's	orders recapitulation					
		sperdal was ordered as					
	follows:	sperdar was ordered as					
		al 0.5 milligrams by					
	_						
	mouth at bedtim						
	symptoms of der						
	_	al 0.75 milligrams 1					
	tablet by mouth						
	_	dal 0.5 milligrams 1					
	tablet twice daily	y.					
	In an interview of	on 5/16/14 at 2:30 P.M.,					
		ed she does not usually					
		t. She spoke to other					
		o told her the resident					
	_	erdal for dementia with					
	_	e the resident thought					
	-	_					
		was cheating on her					
	with staff. She i	ndicated the resident also					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTI A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE COMPL 05/16 /	ETED
	PROVIDER OR SUPPLIEF		98	875 CH	DDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	still hits, yells ar well.	nd scratches at staff as					
	3.1-48(a)(4)						
		nust do the following: e, distribute, and serve ary conditions.					
	This rule was no	t met as evidenced by:					
	record review, the state of 1 facility kind food prep areas, were maintained manner, and followsafety policies and deficiency impact	ation, interview and ne facility failed to ensure tchen food storage areas, and food equipment in a safe and sanitary owed sanitation and food nd procedures. This cted 51 of 51 residents od from the kitchen.					
	Findings include	:					
	tour was comple Dietician (RD) a	0:30 A.M., the kitchen ted, with the Registered and the Dining Supervisor the following was					
	the bottom of the	nad dried debris inside on e pan. Another "well" e on the inside walls,					

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V13I11

Facility ID: 000548

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î ´			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL		
		155472	B. WIN	G		05/16/	2014	
NAME OF I	ROVIDER OR SUPPLIEF	<u> </u>		1	ADDRESS, CITY, STATE, ZIP CODE			
HOOGE				9875 CHERRYLEAF DR				
	R VILLAGE				APOLIS, IN 46268			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE	
	* *	own the inside walls						
		In an interview at that						
		licated the pans should						
	nave no debris o	r moisture in them.						
	The even had a l	baked, black residue						
		tom of the oven floor. In						
		hat time, Dietary Cook e oven was cleaned						
		eved the weekend staff						
	weekly. He bell were to clean it.	eved the weekend starr						
	were to clean it.							
	A sanitation buc	ket containing a						
		on was observed sitting						
	_	table. In an interview at						
		y Cook #15 indicated he						
	· ·	solution in the bucket at						
		I. Dietary Aide #14						
	checked the con-	•						
		on in the bucket, and						
		reading at 100 parts per						
	million (ppm) S							
		on should be at 200 ppm.						
	Samanon Solutio	on should be at 200 ppin.						
	Eleven uncovere	ed bowls of ice cream						
		n the middle shelf in one						
		. The RD indicated the						
		I have been covered.						
	100 Cicain Should	2 114.0 00011 00 t010d.						
	An ice scoop wa	s observed to be in the						
	-	chine. The Dining						
		ated the scoop should not						
	be left in the ice	-						
	machine.							

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	OF CORRECTION	IDENTIFICATION NUMBER: 155472	A. BUII B. WIN	LDING	00 	COMPLETED 05/16/2014	
	PROVIDER OR SUPPLIER		<i>p.</i> ((2)	STREET A	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	dry storage room large dark spot o Supervisor indica to sweep and mo	eath a food rack in the was observed to have a f debris. The Dining ated staff were supposed p daily in dry storage f must have missed that					
	covering of food cleaning of oven	in freezer, schedule for s and the dry storage requested at that time.					
	Dietician provide	which she indicated was					
	Cleaning Schedu indicating which tasks were to be	ment, titled "The Cooks le," was typed out days of the week which completed. There was the list regarding the s.					
		eaning," indicated the was to be organized,					
	An undated docu Handling Guidel indicated "page						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/16/2014			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	in the cooling eq chiller, etc.):I	When the food is placed uipment (walk-in, blast Loosely covered or tected from overhead						
	Sanitizer Techni indicated, "the	concentration of the quat on must be between						
	Control Ice Hand with a revision d "All food and I Department asso in a self-draining	Sanitation and Infection dling" and dated 5/95 ate of 1/14, indicated Nutrition Services ciatesStore the scoop container in an area ontamination. The scoop in the ice bin"						
	3.1-21(i)(3)							
R000000	These deficienci Residential findi with 410 IAC 16	ngs cited in accordance	R000000	This plan of correction constitute written compliance for the deficiencies cited. However, submission of this plan of correction is not an admittant that a deficiency exists or the one was cited correctly. This of correction is submitted to the requirements established the state and federal law.	e ce at plan meet			

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PRINTED: 09/16/2014 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268	COMPLETED 05/16/2014 (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268	(X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268 ID PROVIDERS PLAN OF CORRECTION	(X5) COMPLETION
NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION	COMPLETION
HOOSIER VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	COMPLETION
PROVIDER'S PLAN OF CORRECTION	COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	
R000000 410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION OO			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPI	
	155472		B. WING			05/16/2014	
NAME OF I	ADOLUDED OD GLIDDLIED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF PROVIDER OR SUPPLIER				9875 C	HERRYLEAF DR		
HOOSIER VILLAGE				INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG			TAG		DEFICIENCY)		DATE
TAG	effect with respect subsequent surve available for examplace readily accenotice posted of the (6) Maintaining religibly the division in etwo (2) years and available for inspet the public upon religible as a considerable for inspet the public upon religible. Based on observing facility failed to location of the Irrof Health (ISDH) had the potential residents residing. Findings included During the initian 12:20 P.M., there is seen in the facility location of the Stresults. There we availability of successible to residents residents accessible to residents and interview of A.M., the Reside indicated the location of presents was not presents.	to the facility, and any ys. The results must be a similation in the facility in a sessible to residents and a meir availability. Poorts of surveys conducted each facility for a period of making the reports action to any member of quest ation and interview, the post a notice with the adiana State Department and interview. This is to impact 140 of 140 g in the facility. It tour on 5/12/2014 at was no posted notice ty's entrance lobby of the tate Agency's survey results by any so or any place readily	R00		1.The facility maintains post of the results of the most rece annual surveys in a binder located at the receptionist desall licensed buildings. The surveyor was concerned that although the book was readily available she did not see a noat the desk of the assisted livi facility. Of note, notices were present in the health center. A notice was placed at the front desk of the licensed residentia building the same day the surveyor inquired. 2.There were no residents adversely affected. 3.In an effort to ensure ongo compliance, the receptionist we continue to ensure that the nois maintained at the front desk the licensed residential buildir 4.Quality assurance will be by the Director of Social Serviverifying that the notice is beir maintained to the Quality Assurance Committee quarter	ings nt sk of tice ng vill tice c of ng. met ces ng	06/02/2014

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
	155472		A. BUII B. WIN			05/16/	2014
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HERRYLEAF DR		
HOOSIEI	R VILLAGE				APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
R000187	(k) Hot water temphand washing facian automatic contribution temperature at point maintained between degrees Fahrenhei (120) degrees Fahrenhei (120) degrees Fahrenhei (120) degrees Fahrenhei (120) degrees Hased on observing record review the maintain water to and 120 degrees deficiency had the of 140 residents. Findings included A general observing was conducted on A.M., with Maintattendance. Water temperature checked and four Room 208 124 (F) in the kitcher apartment. 124 degrees F from Room 202 120 kitchenette area of the same and the	endards - Deficiency berature for all bathing and lities shall be controlled by rol valve. Water int of use must be en one hundred (100) eit and one hundred twenty berenheit. ation, interview, and e facility failed to emperatures between 100 Fahrenheit. This the potential to affect 140 residing in the facility. The potential to affect 140 residing in the facility of 5/14/2014 at 9:30 thenance Tech # 6 in The potential areas were and to be as follows: 1.5 degrees Fahrenheit	R00	0187	1.The mixing valve at the mawater heater was reset to belo 120 degrees on 5/30/14. 2.The rooms listed 208, 202 and 307 were of unoccupied apartments therefore, there we no residents adversely affected. 3.Random water temperature will be recorded on a daily base by the housekeepers. Housekeepers will be in-service on 6/3/14 on logging water teand to report any water temperature above 120 degree to maintenance. 4.As a means of quality assurance, the housekeeping supervisor will audit that water temperatures are being record on a weekly basis. Audits will be reviewed quarterly with the Quality Assurance Committee an ongoing basis.	ere d. es is ed mps es	06/03/2014

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	OF CORRECTION	IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CC A. BUILDING B. WING	00	COME	E SURVEY PLETED 6/2014
NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE			9875 C	ADDRESS, CITY, STATE, ZIP C HERRYLEAF DR APOLIS, IN 46268	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	kitchenette area	2.2 degrees F in the of the apartment. at the bathroom faucet.				
		e residents's laundry area 3.4 degrees Fahrenheit.				
	the Director of E on 5/14/2014 at the main water h in the 124 to 126 range. The Dire Services indicate like that and it co by the pipes for	vation and interview with Environmental Services 9:50 A.M., the water at leater was found to be set degrees Fahrenheit ctor of Environmental ed that it had been set build be adjusted. A sign the water heater read 120 rector did not comment				
	Environmental S Executive House	ekeeper on 5/14/2014 at indicated that house temperatures. A nitoring log was				
	Temps Hawthorn was provided. T follows: room 10	paper titled, "Water in Hall" and dated 5/16/14 The rooms listed were as 09118.7, room 136- 41117. No other provided.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155472		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/16/2014			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
R000273	at 11:00 A.M., is the bathroom sin was 124.5 degree. At exit on 5/16/2 information was monitoring water the facility. 410 IAC 16.2-5-5. Food and Nutrition (f) All food preparate (excluding areas is maintained in accollocal sanitation and standards, including Based on observing record review, the proper sanitation preparation equification and standards, and serve conditions. The had the potential the residents curt the assisted living	2014 no additional provided about r temperature logs from 1(f) nal Services - Deficiency ation and serving areas residents ' units) are ordance with state and d safe food handling and 410 IAC 7-24. ation, interview and he facility failed to follow a procedures with food pment, ensure food in the erly covered, labeled and food under sanitary se deficient practices to affect 110 of 110 of rently being served by g kitchen at Hawthorn 0 residents being served he dementia area.	R000273	1.The Manitowac ice machi are designed with a ledge insisthe bin that holds the scoop, not allowing it to touch the ice. This is consistent with the department policy. Both piece equipment were uncovered a they were ready to be in use production staff. The frozen redough was immediately cove and labeled with a bakers can bag. The sheet of uncovered brownies in the dining area or memory care area was being served at that meal. Food ser #11 was immediately re-in-serviced on proper hand washing techniques. The faci considers this a rare departure.	ide while e. es of s by coll red t f the ever		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED		
		155472	B. WING			05/16/20	05/16/2014	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					HERRYLEAF DR			
HOOSIE	R VILLAGE				APOLIS, IN 46268			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	On 5/12/2014 at	10:30 A.M., the ice			its hand washing policy. 2.There were no residents			
	machine by the s	soda dispenser was						
	observed with th	ne door to the ice machine		adversely affected 3.In an effort to ensure ongoing				
	onen and an ice	scooper was lying on top			compliance, the ice scoop will	_		
	of the ice.	secoper was lying on top			maintained on the ledge in the			
	of the ice.				bin at all times. All Hawthorn			
	On 5/12/2014 -4	4.20 D.M. the :			Dining Services Employees wi			
		4:30 P.M., the ice			be in-serviced per policy on			
		served with the door			proper covering, labeling, and	<u>, </u>		
		e scooper was observed			dating of products per policy. A memory care staff will be	All		
	in with the ice. At this time the Food Service Assistant Supervisor # 9				in-serviced on proper hand			
					washing techniques. In-service	es		
	indicated the scooper should not be in with the ice and removed it.				to be conducted on 6/2/14,			
					6/3/14, 6/10/14 and 6/12/14.			
					All dining service staff have a			
	Record review	rd review, of the facility's,			daily checklist to include prope			
		Infection Control			covering, labeling and dating of			
		dling," date revised: 1/14,			products. Dietary managers w perform weekly visual checks			
	"	•			ensure that staff are following			
	•	on 5/14/14 at 12:10 P.M.,			policy on proper covering,			
	and indicated th	•			labeling, and dating of product	s.		
	_	in a self-draining			4.As a means of quality			
		area protected from			assurance, the weekly visual			
	contamination.	The scoop cannot be			checks conducted by the dieta			
	stored in the ice	bin, unless the container			supervisor will be reviewed with the Quality Assurance	,11		
	for the scoop is placed in a way that does				Committee, quarterly.			
	not allow the ice	e scoop handle to come in			den manage, quanten y			
	contact with the	•						
	On 5/12/2014 at	10:40 A M a meat						
	On 5/12/2014 at 10:40 A.M., a meat cutter and mixer were observed uncovered. At this time what were identified by							
		olls" were observed, in						
	the walk in freez	zer, on a rack uncovered,						
	and unlabeled.	Cook # 10 indicated, at						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SU COMPLE - 05/16/2	TED		
NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
		ere suppose to be covered did not know why they like they were.						
	and Supply Storarevised: 1/14 was at 12:15 P.M., at following: "Frozen storage approved confitting lids. LablidWrap food contamination. first in, first out On 5/13/2014 at memory care ass facility Food Set serving the food residents in the I brownies was obleft as the server memory care are returned and the to have been pla return. On 5/13/14 at 12 #11 was observed 4 seconds between	Store bulk materials in tainers that have tight el both the bin and the tightly to prevent cross Date and rotate items; (FIFO)." 12:35 P.M., in the B sisted living area of the rver #11 was observed on to the plates of the B area. A large sheet of eserved uncovered and went to area A of the ea to serve. The server brownies were observed ced in the oven on her 2:35 P.M., Food Server ed washing her hands for en going from area A and emory care areas.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155472	B. WING		05/16/2014
	PROVIDER OR SUPPLIE	ER .	9875 C	ADDRESS, CITY, STATE, ZIP CODE HERRYLEAF DR JAPOLIS, IN 46268	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	RIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	"Sanitation and	Infection Control.			
	Subject: Hand l	Hygiene," date revised:			
	1/14 was comp	leted on 5/14/14 at 12:20			
	P.M., and indic	ated the following:			
	"Wet hands wit	h warm water and apply a			
	disinfectant soa	p, lathering up to			
	mid-arm. Worl	k lather into hands for 20			
	seconds, includ	ing areas under			
	fingernails, between fingers, on the inside				
	_	nands. Keep hands away			
		nk. Rinse thoroughly			
		nning water, allowing the			
		om the arms, down to the			
	fingertips"	om the arms, down to the			
	ingerups				

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